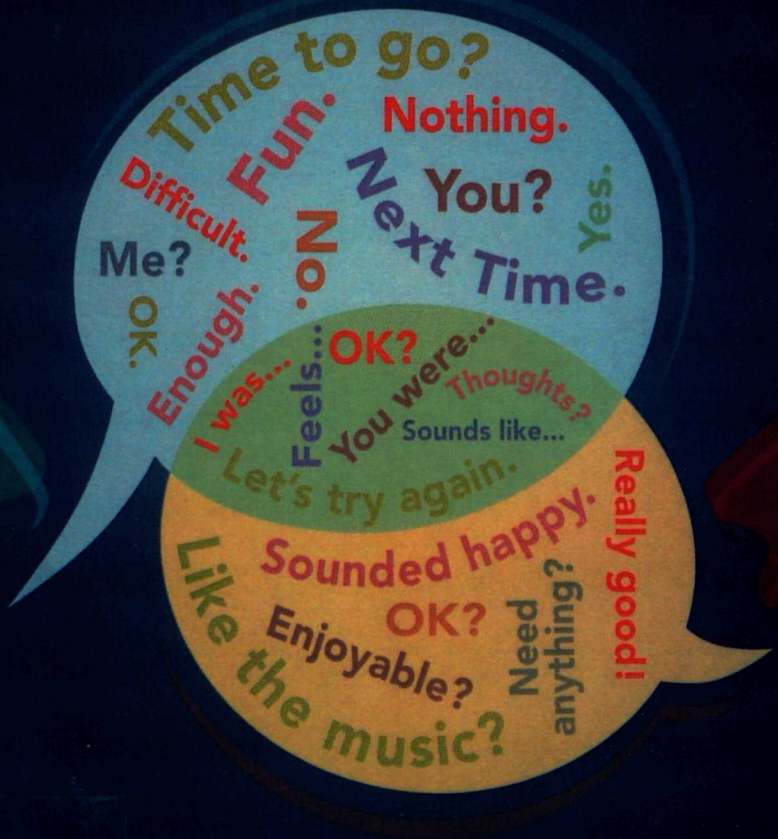
Basic verbal skills for Music Therapists



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Elizabeth K. Schwartz

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Barcelona PUBLISHERS

Basic Verbal Skills for Music Therapists

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Dedication

With humble gratitude to Ken Bruscia,
who gave voice to my voice, and the voice of so many others.

PREFACE

I was barely in my 20s when coincidence (or fate) brought me to a cavernous classroom at the Crane School of Music with two people who would forever change my life: Clive and Carol Robbins. In the years that followed, I became their student, apprentice, disciple, colleague, and, hopefully, friend. Their total commitment to spreading the message on the power of music for children with disabilities became woven into every fiber of my being.

All these years later, Carol's exquisite musicianship and clinical accuracy seem to float in the background during every session. Clive's passion for the humanness of music-making drives me to continually drill into the depths of the music.

I guess this connection has led some to refer to me as a "music-centered music therapist." Frankly, I have a very hard time understanding those words. Isn't every music therapist music-centered? How can music therapy not be music-centered? Now as an educator and supervisor, I see that my young students will often roll their eyes when they repeat back to me the mantra that I teach them: "Music is enough. Trust the music." (I've also been known to sit in the back of the room with a handwritten sign reading "No Talking!" while a young intern begins a session.)

So, what would motivate me to write a book about verbal skills in music therapy? All I know is that the way I learned to practice from Clive and Carol taught me that every single note, every single chord, every single rhythm, and yes, every single word we use with our clients should have intent, meaning, and purpose. If my clients need words for the therapy to be effective, I want to choose words with the same care that I use to choose the music. My hope is that this book will help students, young professionals, and educators think more deeply about words in the same way in which they think deeply about music—to choose every word and every element of music with intention.

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INTRODUCTION

Words. This book is filled with them. The fact that words are used exclusively in this volume supports its premise that basic verbal skills are necessary for effective and competent practice at every level of music therapy. The intersection of words, language, and music is strong. Cognitive neuroscientist Aniruddh Patel (2008), in his book *Music, Language, and the Brain,* summed it up in his first paragraphs:

> The central role of music and language in human existence and the fact that both involve complex and meaningful sound sequences naturally invite comparison between the two domains (p. 3).

In music therapy practice, the value and importance of words in treatment has long been a subject for debate. In *Music Therapy in Context: Music, Meaning, and Relationship,* Mercédès Pavlicevic (1997) raised serious questions concerning the deep divide already present about the meaning and use of words in music therapy. Kenneth Aigen (2014) later devoted an entire chapter to the topic in *The Study of Music Therapy: Current Issues and Concepts* (pp. 91–106). The complex implications of this dispute will be interwoven throughout the coming chapters. However, the intention of this book is not to advocate for one way of thinking but to provide a basis for understanding how words and verbalization can be used in a variety of ways in music therapy to meet the individual needs of each client across a range of settings. The focus will be to give music therapy students and young professionals a roadmap for deciding why, when, and how to use basic verbal skills in their work.

To begin, there needs to be a common understanding of the forms and structures of human communication, of which words are just a part. Many music therapy students use words such as "speech" and "communication" interchangeably without fully understanding the tiered nature. Chapter 1 will look concisely at aspects of communication, including gestures, affect, and posture; words, speech, and language; and, of course, music. Focus will be on the differences as well as the intersections. This first chapter is designed to help organize thinking to support more deliberate and targeted choices of modes of communication within therapy, including verbal skills.

One impetus for compiling this book comes from the limited number of articles, chapters, and books on verbal skills within music therapy. Chapter 2 will review the current music therapy literature, exploring writings on verbal skills from a selection of authors, including Aigen, Amir, Bruscia, Gardstrom, Gooding, Nolan, Pavlicevic, and Silverman. All of these authors advocated for greater understanding and study of verbalization within music therapy practice. Again, the main thrust of this book will be on developing basic verbal skills, with the appreciation that concentrated study of these pioneering works will give students greater depth and insight.

The following chapters will walk you through the process of determining which types of verbal skills you can, or could, ethically employ. Use of verbal skills in therapy is closely tied to professional scope of practice. As the music therapy profession seeks legal and regulatory recognition across the United States and other countries, there are increasing questions about practice boundaries. This is particularly meaningful since many U.S. states regulate professions that use verbal interventions, such as psychotherapy. Music therapists also need to address professional boundaries with respect to other disciplines that involve the use of words and language, such as speech therapy and mental health counseling. Chapter 3 will begin by looking at music therapy's scope of practice as defined by professional and regulatory bodies and will link scope to the use of verbal skills. This will aim to clarify the use of Verbal

Interventions with respect to professional scope of practice as defined by law in an ever-changing regulatory environment.

Organizations and agencies regulating music therapy's scope of practice, though, provide only general guidance on what the individual therapist can or cannot do when it comes to using Verbal Interventions. To give more detailed guidance, Chapter 4 will outline commonly accepted levels of practice in music therapy and explore how verbalization fits into each level.

Regulatory oversight and ethical standards are a basic starting point for determining the use of verbalization for the therapist. However, the decision of how, when, and why to use words or music as a primary intervention cannot be separated from the theoretical foundation within which a person works. Music therapy has long struggled to define itself from an indigenous theoretical perspective. This book will not pretend to answer the theory dilemma but will try to place the decision to use music or words within a related context: agent of change. Chapter 5, then, will present thoughts on determining which vehicle—words or music—provides the impetus for change within a specific and individual therapeutic context. This will include a short analysis of the primary agent of change in various models of music therapy currently practiced.

Chapter Six circles back to the client and the client's rights to ethical and competent practice, including the use of verbalization. This should be a key consideration for the therapist. To help with making an informed clinical decision, the chapter will propose and examine four different categories of verbalization—Verbal Framing, Verbal Exchanges, Verbal Interactions, and Verbal Interventions—and investigate which of these might be the best choice for the client at any given moment with respect to the therapist's level and scope of practice.

The bulk of the book will be organized according to the proposed function and purpose of using spoken language within music therapy, that is, Verbal Framing, Verbal Exchanges, Verbal Interactions, and Verbal Interventions. Each of these organizational categories will have its own chapter. Included will be short clinical stories that illustrate why we need to

clearly plan how, why, and when to use each type of verbalization for the most effective treatment for the client.

The final two chapters of the book will look at how words and music are intertwined in practice. Chapter 12 will guide readers in thinking about the meaning infused in speech and language by pitch, meter, rhythm, dynamics, timbre, and other musical properties. There will be a series of explorations guiding how to use purposeful musical qualities within word use to help readers see the connection between music and interactive verbal communication. Chapter 13 will end the exploration of words and music by guiding the reader to investigate music through the use of words.

Throughout the book, you will be invited to expand your understanding through exercises designed to help with verbal skill development. These exercises allow for three different levels of skill-building:

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

Repertoire: Curate samples of words, phrases, or sentences that can be used within different types of verbalization in each section.

Rehearsal: Use sample vignettes to imagine or role-play scenarios in which you would use verbal skills and practice them as a foundation for actual therapy.

Basic verbal skills for Music Therapists

Chapter 1

COMMUNICATION, MUSIC, AND VERBAL EXPRESSION

Some words are used so frequently, and encompass such complexity, that we rarely stop to think of their precise meaning. "Communication" and "music," two words vital to music therapy practice, are in that category. Specific, simple definitions of them seem close to impossible. For our purpose, this complexity will be embraced while still acknowledging the necessity of identifying distinctive components of each. An analogy might be a steaming pot of Grandma's soup bubbling away on the stove. Grandma can write down the recipe. You can assemble all the ingredients yourself. You can put them together to make soup. You know exactly what is in it. But Grandma's soup is more than just individual ingredients. The flavor and smell holds your memories and connects you to your family and community. One spoonful can bring back feelings and sensations. There are attributes to the soup that are way beyond its individual physical properties.

So it is with "communication" and "music." These two short words, and their specific parts discussed below, are just a label for a deeper and more amorphous understanding of these significant aspects of our humanness.

COMMUNICATION

It is interesting to learn that the origins of the word "communication" come from French and Latin words that meant having something in common, connecting, or sharing *(Oxford English Dictionary)*. Later usage of the word diluted its meaning to the exchange or transmission of information *(Britannica*

Academic). In its current use, the term "communication" is often equated with speech or written language. The American Speech-Language-Hearing Association (ASHA) uses the term in its Vison statement: "Making effective communication, a human right, accessible and achievable for all" (https:// www.asha.org/ about/). The American Music Therapy Association also indicates that communication is a focus of treatment: "Music therapy also provides avenues for communication that can be helpful to those who find it difficult to express themselves in words" (https:// www.musictherapy.org/about/quotes/). These two professional organizations invoke the same word, "communication," but might have very different ways of approaching the concept of human communication in therapy.

As music therapists, we are keenly aware that our clients communicate, or wish to communicate, in a way that brings us back to the original meaning— to have something in common, to connect, to share. Clients engage in a variety of means of communication that might include not only words, speech, and language but also an assortment of other communication methods such as gestures, physical actions, and, of course, music. All of these discrete modes are arguably equally effective in communicating. Each allows for sharing and connection, but each operates in a different domain of experience, from cognitive to social, emotional, or aesthetic. Words share experiences in a very different way than music does. Music shares experiences in a very different way than words. While cultural norms can suggest there is a hierarchy of communication methods (often putting words and language first), in this broader way of thinking, each method of communication has a place in therapy, as in life.

Let's imagine a scenario where two people are meeting after a romantic breakup. They can talk about the separation, explaining on a cognitive and linguistic level all the intricacies of the collapse. They can write each other long letters of apology, again a cognitive and linguistic sharing of information. They can meet at a local pub and cry while the band plays a song of significance from their early years, sharing in a mutual experience of emotion that communicates wordlessly. They can

look into each other's eyes and then hug. Which is the best way for these two star-crossed lovers to communicate? Words? Music? Gestures? Maybe every one of them is valid, each in a different way. All allow for communication with a unique focus.

Music, words, gestures, and physical actions are each components of communication that will be viewed here as valuable interventions to help a client communicate. For the purposes of this book, the broad meaning of the word "communication" will be used when considering how, why, and when to use words or music in music therapy treatment. As music therapists, we have the unique education and training necessary to provide effective music as a primary intervention that can give the client a communicative avenue. However, it is our clinical responsibility to also understand and determine when, or if, one of these other avenues, such as words, gestures, or physical action, will be a more effective intervention.

LANGUAGE

A word that generally comes to mind when considering communication is "language." One definition of language is "... a system of communication by speaking, writing, or making signs in a way that can be understood, or any of the different systems of communication used in particular regions ..." *(Cambridge English Dictionary).* Language, then, is an organizational system made up of discrete components. Language also relies on context. Language has meaning only within a social, cultural, or relationship context. There is a good example of this in sports. The game of baseball seems to have a gestural language all its own that clearly has meaning to its players but can seem like random movements to anyone else. Infants could be said to have a language of sounds and vocalizations that most parents learn to interpret early on. In the context of a parental relationship, the child and parent clearly have a language that each must learn in order to get through the first year.

Is music a language? This simple question has caused considerable debate across a number of music disciplines. From

a music cognition perspective, Patel (2008) encourages examining the relationship between music and language:

> The comparative study of music and language provides a powerful way to explore these mechanisms. These mechanisms include the ability to form learned sound categories ... to extract statistical regularities from rhythmic and melodic sequences ... to integrate incoming elements (such as words and musical tones) into syntactic structures ... and to extract nuanced emotional meanings from acoustic signals .... (p. 4)

Music therapists Wigram et al. (2002) answer the question with an unequivocal "yes":

> Yes, music is a type of language—in the sense that music is an art or expression that follows certain perceptive and syntactical rules. It has an indigenous notation system (musical notation), and it has meaning for most people. However, music is not an unambiguous, discursive language and it can never represent or designate phenomena of the external or internal world with the exactness of verbal, categorical language. (p. 39)

How to think about language when making clinical decisions about verbalization? As the music therapist, you can incorporate a client's communicative attempts, whether words, music, gestures, or physical actions, into a shared organizational structure within a meaningful context. Language, then, is not reliant on words or speech but on a shared structure of meaning. The language of music or the language of words can be seen as two valid choices. The music therapist and the client can determine the most appropriate language in which to communicate.

How does this facilitate development of clinical verbal skills? Understanding and respecting the inclusive definition of

language can help to place value on individual client responses, whether linguistic or musical. It can help in deciding when and why to move toward words as an intervention. It allows the music to be seen as having a language structure with the capacity to be understood within the social configuration of the therapeutic relationship and perhaps beyond. Music will be the intervention when the musical language created includes meaning for both the client and therapist. Words will be used when either the client or the therapist seeks a different level or form of meaning.

MUSIC

Here is a prime example of using words to describe something that is beyond words—music. The *International Dictionary of Music Therapy* (Kirkland, 2013) begins its definition of music by saying ...

> Music has been conventionally defined as the art of sound in time, or the temporal ordering of successive, or combined sounds (vocal, instrumental, and/or mechanical) that express ideas and emotions in coherent and cohesive ways, via elements such as timbre, rhythm, melody, and harmony. (p. 79)

Bruscia (2014) defines music as ...

> ... the human institution in which individuals create meaning and beauty through sound, using the arts of composition, improvisation, performance, and listening. Meaning and beauty are derived from the intrinsic relationships created between the sounds themselves and other forms of human experience, as well as the universe itself. (p. 41)

Perhaps the best definition of music would be presented if these pages were to suddenly melt away to be replaced by the sounds of your favorite song or musical experience.

Both of the written definitions of music above support the inclusion of music as a form of communication. The expression of ideas and the creation of meaning can easily be seen to fit into the act of sharing or connection. What becomes difficult for the music therapist, though, is to translate music expression or meaning for those not immediately involved in the experience without resorting to words. This is a conundrum that often plagues the music therapy profession in our word-driven culture. This does not mean that it is any less of an important human experience. This equity of value needs to be respected in considering why, how, and when to use words versus music in music therapy.

Music, like verbal expression, is made up of discrete components that are combined in specific ways to create a communicative structure. These components include pitch, rhythm, dynamics, timbre, intervals, melody, harmony, and form. There is an almost limitless vocabulary of musical sounds that can be made by combining aspects of each element. This might be one reason that musicians keep turning out new and novel songs. Will there ever be a finite number of melodies? Would we ever run out of rhythmic pattern combinations? These questions might seem silly, but no sillier than asking if and when there will be no more books to be written because we have run out of ideas and words.

Many in the music world are also studying, researching, and arguing over whether individual components of music have a fixed meaning when not connected to a culturally situated whole. Does an interval of a descending third "mean" the same thing in the Western Hemisphere as it does in a country thousands of miles away? Does everyone in the world experience a glissando with the same sensory, cognitive, or emotional response? How would a fixed meaning even be understood or explained using words? This book does not seek to answer this question, but it does ask the mindful music therapist to think about and ponder how the components of music and the components of verbal expression are similar and how they are different.

Gestures and Physical Actions

There can be no doubt after observing everyday human behavior that gestures and physical actions can communicate. Many famous (and infamous) examples are part of most if not all cultural traditions and history. Gestures that signify power, such as a raised fist in a political protest or the downcast eyes and head of a person experiencing grief, can be immediately recognized and understood by others in the community. In some cultures (or in the example of baseball above), gestures are combined in an organized structure to create a language or language-like composition.

There is a huge number of individual components of gestures and physical actions that are used to communicate. Too many to list, these might include a shrug of the shoulders, upturned palms, a shake of the head, or a wiggle of the hips. In order for these gestures to accurately communicate, though, there needs to be a shared understanding of meaning that is accepted within each specific community. If you have traveled outside of your home country, you might have learned the hard way that a specific gesture used in your community might mean something very, very different in another region.

Gestures and physical actions can be viewed to have musical qualities that contribute to the communicative meaning. Gesticulating with a quick, staccato jab communicates something very different from a slow, legato sweep of the arm. Although beyond the scope of this book, gestures and physical actions as communication are an important area of attention for music therapists.

Verbal Expression

Verbal expression is communication, but not all communication is verbal expression. However, a drive toward verbal expression seems to be significant in the human experience. As with music and gestures, it is a means of communication that has evolved and is used throughout most societies. In many cultures, verbal expression is a prime mode of communication. The *Merriam*

Webster Dictionary defines verbal as "of, relating to, or consisting of words." By some accounts, there are over 6,500 different spoken languages used around the world. Each spoken language has its own set of phonemes (letters or sounds), words, grammar, and structure.

Just like music, verbal expression includes stand-alone components that are necessary but which do not begin to convey a complete meaning. As an example, let's look at three discrete words: "I," "love," and "you." Each one used separately creates the opportunity for understanding a unique aspect of a human being. Combining them into a structure—"I love you"—allows for a larger understanding of the human experience.

As already seen, there is often confusion when using the words "communication," "language," and "speech" interchangeably. To help with clarity, the terms "verbal expression," "verbal discourse," "spoken language," or "verbal skills" will be used to denote the use of words and grammar to communicate. Despite commonly held preconceptions, the problem of precision in meaning does not always get clearer with verbal language. This book, then, will attempt to be very precise in the use of words and in the proposed categories of Verbal Framing, Verbal Exchanges, Verbal Interactions, and Verbal Interventions.

As with all communication, spoken language requires shared meaning that is specific to the society or community. A word or phrase can have a significantly different purpose when used in different situations and with different communication partners. One familiar example is the generational gap seen when words used by one age group morph into an entirely different intent with the next generation. A modern example is the word "cell": In years past, this was a jailhouse enclosure. Today, it is short for a communication device—the cell phone.

SPEECH

The *English Oxford Dictionary* defines the word "speech" as "the expression of or the ability to express thoughts and feelings by articulate sounds." Speech is how humans formulate the sounds

that produce words. Speech can also be used to indicate the use of words to communicate. As we begin the journey to understand verbal skills in music therapy, the word "speech" will be used as another way to describe the use of spoken language.

Speech, verbal expression, and spoken language frequently include musical qualities that can change or enhance communicative meaning. This topic will be explored in greater depth later in the book.

Using verbal expression as a therapeutic intervention in music therapy requires the same level of intentionality as when using music. For the music therapist, a deep exploration of communication, music, and verbal expression can be critical in knowing why, when, and how to make the most appropriate clinical intervention choice for the client. The following chapters will begin to explore how to add effective, and ethical, verbal skills to your clinical practice.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Explore your use of music and your use of words in everyday situations. When and how do you use words to communicate? When and how do you use music to communicate?
- Are there situations where you feel that only words can accurately communicate for you? Only music?
- Spend time with another therapist, such as a psychologist or social worker, who uses words and verbal expression as their primary intervention. How do they think about words? Do they consider other avenues of communication in their work?

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Keep a journal of words that you use that might have multiple meanings depending on communicative intent.
- Write a list of words that you associate with your music therapy practice.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Judy had a massive stroke at age 47 that left her completely paralyzed. You are the first clinician to visit her besides the medical team. What mode of communication does she use with you? What mode of communication do you use with her? Role-play how the different choices of communication would feel to you or to Judy.

Chapter 2

VERBALIZATION IN MUSIC THERAPY LITERATURE

Music therapy is unique precisely because it is in and around the experience of music that a person encounters the opportunity for therapeutic change. Nevertheless, the use of words and spoken language within sessions seems inevitable. Music therapists include verbalization in their work for a variety of purposes. A review of music therapy literature, though, reveals only sparse discussions of clinical verbal skills as integral to practice. Music therapy education and training have also focused largely on developing therapeutic music skills, with development of verbal skills as secondary.

Why this scarcity of focus on verbal use? Two main themes stand out when reviewing the literature on verbalization in music therapy.

The first can be traced to the history of music therapy and its initial struggle for recognition as a profession. Early writings eagerly sought to elevate the place of music as a therapeutic medium. *Music in Therapy,* edited by E. Thayer Gaston (1968), included a significant chapter titled "Processes in Music Therapy" by the foundational music therapy figure William Sears. In it, Sears concisely and compellingly identifies a list of qualities to prove music's value in therapy. These items are organized into three broad classifications: experience within structure, experience in self-organization, and experience in relating to others (pp. 33–34). The focus is solely on music, as might be expected when making a novel argument for a new way of thinking. But Sears cautions the reader, "No attempt is made here to describe how music or music therapists can be used in combination with other therapeutic approaches" (p. 30).

One can imagine that in this time period, any deviation from a narrow focus on music would undercut the primary premise. Music therapists were out to prove themselves and their principal therapeutic medium—music. Sears himself chose to expand his earlier thinking in a 1979 presentation at the annual conference of the National Association for Music Therapy. In this revision of his original Processes framework, Sears (2007) included verbal interaction within the newly renamed classification Social Relations (p. 23). Perhaps as Sears's thinking grew along with that of the profession, there was a greater willingness to be more expansive in understanding music and music therapy experiences to include words.

A second possible explanation for the limited literature on verbal skills in music therapy in the early years could be related to the general climate within music therapy associations. Up until the mid-1990s, there were two main professional organizations in the United States—the National Association for Music Therapy (NAMT) and the American Association for Music Therapy (AAMT). The differences between the two were often painted in stark terms by educators, clinicians, and researchers. In a joint article with Bryan Hunter on the unification of both organizations into AMTA, or the American Music Therapy Association, Kenneth Aigen recalls: "I had been looking at some of the conflict between AAMT and NAMT as due to philosophical differences in educational and treatment approaches. AAMT appeared to be guided primarily by a humanistic orientation, and NAMT appeared to be guided by a more behavioral orientation" (Aigen & Hunter, 2018, p. 187). They later explained more fully: "... AAMT clinicians supported clinical models such as Guided Imagery and Music, Nordoff-Robbins Music Therapy, and Analytical Music Therapy; areas of advanced clinical practice such as music psychotherapy; and humanistic and transpersonal philosophical perspectives ..." (2018, p. 192). These models of practice, particularly Analytical Music Therapy and music psychotherapy, were closely aligned with psychotherapeutic practices that relied heavily on verbal processing. It could be argued, then, that the use of words and

verbal skills in music therapy was one factor dividing music therapists into separate factions of practice in the early years.

Two key figures who bridged the divide between the two different organizations were Kenneth Bruscia of Temple University and Paul Nolan from what is now Drexel University. Their programs were approved by both NAMT and AAMT (Aigen & Hunter, 2018, p. 184) and taught students the skills necessary to work within any theoretical framework. It is probably no surprise, then, that Bruscia and Nolan were the authors of some of the earliest music therapy literature that investigated the use of verbal skills within music therapy practice. Their ideas and thoughts will be explored below and throughout this book.

An early path to understanding the use of words and verbalization in music therapy was incorporated into a conceptual framework offered by Barbara Wheeler in 1983. Wheeler proposed a three-level approach to music therapy: music therapy as an activity therapy, insight music therapy with re-educative goals, and insight music therapy with reconstructive goals. In the first, verbalization centered only on particular events of the music experience, with "minimal discussion" of related feelings (Wheeler, 1983, p. 10). For insight music therapy with re-educative goals, "... the music is frequently used as a stimulus for verbalization, and the thrust of the therapy is toward the insight achieved through discussion" (p. 11). She cautions that insight music therapy with reconstructive goals should be employed only by music therapists with highly specialized training, presumably including specific experience in verbal processing.

In 1987, Kenneth Bruscia published a comprehensive book, *Improvisational Models of Music Therapy*, which thoroughly surveyed improvisational music therapy practices of the time. Bruscia states that "... improvisational models may employ various expressive modalities and media. The main modalities are music, verbalization, movement/dance, drama, poetry, and art" (1987, pp. 12–13). A number of the models included verbalization as a key component. Some, such as Analytical Music Therapy, placed Verbal Interventions on a par with

musical interventions (p. 115). Bruscia clearly laid out the why, when, and how of verbalization within each model. In the final unit of this massive volume, he offers a clear summary and synthesis which provides guiding principles for use of verbalization in music therapy. Framed within a discussion of music as therapy or music in therapy, the section bears repeating here in its entirety as we work toward a foundation for the understanding and development of verbal skills.

- Music may be appropriately used as therapy under any of the following conditions:
  - ... when the client is inaccessible to Verbal Interventions;
  - ... when the client is not prepared or developmentally ready for verbal insight;
  - ... when the client needs the context or pretext of music to interact, communicate, or relate to another person; or
  - ... when the client can achieve therapeutic growth directly through the music and does not need to verbally work through a personal relationship with the therapist.
- Music may be appropriately used in therapy under any of the following conditions:
  - ... when the client is not accessible to musical intervention;
  - ... when the client needs to verbalize his/her insights and is ready to do so;
  - ... when the communication or relationship problems need to be resolved through verbal as well as musical means;
  - ... when the client can achieve therapeutic growth more directly by verbally working through a personal relationship with the therapist. (Bruscia, 1987, pp. 503–504)

Bruscia reiterated these ideas many years later in the third edition of *Defining Music Therapy* when dissecting and analyzing the term "process" within his definition:.

> Finally, music therapy often involves verbal dialogue between therapist and client and between clients. The dialogues are used as or in therapy, similarly to the way in which music can be used, and because both music and words are the means of interaction and communication, the utilization has to be considered in tandem. Thus, music can be the focus with verbal discourse as facilitative; music and verbal discourse can be used in tandem; and verbal discourse can be the focus with music as facilitative. Once again, these ways of working may shift from one experience to another or from one session to another. (Bruscia, 2014, p. 46)

It is critical to note that Bruscia does not place the use of music and the use of verbal discourse within a hierarchy. His approach, as well as that of this book, is for music therapists to have the knowledge and competency to make ethical decisions on appropriate clinical methods and means that are driven by the needs, wishes, and motivations of the client. This includes responsive, client-focused verbal skills. Bruscia gives us clear direction on how to do this by including verbal discussion techniques in his groundbreaking taxonomy of techniques used in improvisational music therapy. His "Sixty-Four Clinical Techniques Used in Improvisational Music Therapy" (Bruscia, 1987, pp. 533–557) will form the backbone of much of the organization of this book in later chapters.

A full 10 years later, Mercédès Pavlicevic dove deeply into the debate of words and music in music therapy in her 1997 volume *Music Therapy in Context: Music, Meaning and Relationship*. Her intricate and sophisticated examination led to this alarming statement: "Certainly, current debate among music therapists suggests that the question of 'verbalising' has generated a crisis in music therapy thinking" (Pavlicevic, 1997,

p. 11). Pavlicevic draws on the work of many profound thinkers in and out of music therapy to present an in-depth discussion of verbal language and music therapy. However, she places her own theoretical musings in a context similar to that embraced by Bruscia in writing: "This sane reminder jolts us into a critical reality: that the needs of clients and patients are paramount, and that in theorising and speaking about the work, we owe them—and our work with them—an integrity that is beyond sophistry and intellectualisation" (1997, p. 14).

The late 1990s saw two articles on verbal skills in music therapy written from two very different perspectives. Wolfe et al. (1998) designed research to systematically study the verbalizations of a music therapist working in group settings with a goal of soliciting verbal expression among the members. The results indicated that the therapist's verbalizations fell into three broad categories:

- Continuing responses designed to encourage members to keep talking. Subcategories included verbal sounds such as "Mm-hmm"; the use of reflecting, echoing, or paraphrasing; or attempts to identify client feelings.
- Leading responses in which the therapist verbally initiates, including influencing/reinforcing, advice-giving, and questions/directives.
- Other categories, including instruction, explanation, self-disclosure, openings, and closure. (Wolfe et al., 1998, p. 15)

The researchers also suggest a number of ways in which music therapy educators could assist students in becoming proficient in using verbal skills within music therapy by providing opportunities to practice:

- giving brief instructions on music therapy procedures
- articulating the purpose of the music therapy session
- connecting procedures to specific music therapy objectives
- paraphrasing and clarifying verbalizations

- effectively listening
- reflecting, summarizing, and clarifying what others have said
- asking appropriate questions
- expressing their own reaction or feelings to the music
- preparing a list of reinforcing words and phrases
- giving more descriptive verbal reinforcement
- preparing for "in-the-moment" group member responses (Wolfe et al., 1998, pp. 16–19)

In 1999, Dorit Amir published a quantitative study comparing musical and verbal interactions. Through data-gathering and subsequent analysis from six experienced music therapists, she provided fascinating insights into the use of music and words in therapy. This contained a list of the participants' ideas about the general function of Verbal Interventions:

- To open a space for understanding, awareness, and clarity within the client's rational, cognitive mind
- To check issues that deal with content, descriptions, and analyses
- To get to the known, natural, and familiar mode of communication
- To take a distance, to be less involved, so that one can look at the experience from a different angle
- To make an interpretation
- To bring clients back from the unconscious to the conscious, from fantasy world to reality, from altered state of consciousness to regular consciousness
- To acknowledge and give meaning to the experience: Sometimes, not to talk about it is almost to say that it didn't happen (Amir, 1999, p. 167)

Amir also highlighted a number of factors that influenced the therapist in the decision on which intervention to use, words or music. These factors included the therapist's theoretical orientation, own experiences with words and music, knowledge

of the client, professional knowledge of the therapeutic process, countertransference issues, belief in music and its therapeutic power, belief that use of music was part of the therapist's role, musical ability, and training in verbal psychotherapy (Amir, p. 168). In a summation statement, though, Amir came to a conclusion that echoes that of Bruscia and Pavlicevic:

> During the first stages of analysis, I became aware that it was very important for me to prove that musical interventions are more meaningful and powerful than verbal interventions, and my analysis was too subjective in this sense. When I realized that, I had to go over the data again and again and look at it in a more objective manner. Only then could I see that each kind of intervention has its own unique meaning and power. One is not more important than the other, but different. (Amir, 1999, p. 173)

In 1998, Bruscia continued his exploration of verbalization in music therapy through the publication of *The Dynamics of Music Psychotherapy*. As with his previous works, Bruscia sought to synthesize thoughts about verbal practice in a manner that could clearly inform the field. In the introductory chapter, he drew a line between two distinctively different approaches to music psychotherapy: transformative music psychotherapy, in which "... it is the music experience itself that leads to change," and insight therapy, in which "... the aim is always verbally mediated insight" (Bruscia, 1998, pp. 3–4). It is easy to see how words and Verbal Interactions fit into each of these forms of therapy.

It is clear from the reporting so far that examination of verbalization in the literature focused primarily on studying and writing about highly experienced music therapists already in the field. How would a young professional or student gain these necessary skills? Susan Gardstrom (2001) addressed that question in an article in *Music Therapy Perspectives* concentrating on developing complementary skills in improvisatory music

therapy. She offers highly workable steps to develop the use of verbal language and verbal processing.

- First, discover and refine musical vocabulary by naming, listening to, and playing the musical elements (Gardstrom, 2001, p. 84).
- Next, Gardstrom gives a number of specific ways to practice and role-play verbal processing using a common counseling technique called the probe. She organizes use of the probe by grouping the intended therapeutic outcome into domains of function: cognitive, physical/motoric, emotional, social/interpersonal, and general, including eliciting discussion about music, choices, and moving on. (2001, pp. 85–86)

In her later book *Music Therapy Improvisation for Groups: Essential Leadership Competencies*, Gardstrom writes in more detail about verbal processing skills. In addition to the probe, Gardstrom pulls from improvisation to suggest the following verbal processing techniques: reflection of feeling; clarification; checking out; self-disclosure, and summary (Gardstrom, 2007, pp. 136–140). These techniques are in large part based on the "Sixty-Four Clinical Techniques Used in Improvisational Music Therapy" as outlined by Bruscia in *Improvisational Models of Music Therapy* (Bruscia, 1987, pp. 533–557) discussed above. In later chapters, these same "Sixty-Four Clinical Techniques" will be revisited as foundations for developing verbal skills in music therapy.

In 2004, Ronald Borczon tackled a more immediate concern of educators: how to train novice music therapy students for general practice, including effective verbal skills. He devoted an entire chapter in his *Music Therapy: A Fieldwork Primer* to "Talking As an Intervention." This condensed but informative chapter is still used widely in education and training programs. Borczon bypasses the issue of theoretical orientation and moves directly to the practical matter of using words. He suggests that deciding when and how to use verbal techniques needs to take both the developmental level of the client and the goals of the session into consideration. He outlines and explains a number

of verbal techniques, including questions, verbal reflections of feelings/music, restatement of content, and noticing incongruence between the client's words and actions. He gives practical suggestions, such as "use your own words sparingly"; "it is okay to be silent"; "when in doubt, focus on the feeling"; and "avoid trying to solve the client's problem" (Borczon, 2004, pp. 48–68). The chapter also offers sample dialogue and clinical situations that provide guided practice in verbal skills for the beginning therapist.

One of the most targeted writings on developing verbal skills in music therapy came from Paul Nolan, then the director of music therapy education at Drexel University in Philadelphia, Pennsylvania. The 2005 Special Feature article in *Music Therapy Perspectives* focused specifically on verbal processing, which Nolan defines as "... the talking that facilitates the therapeutic process during, and in response to, music-making or music listening" (Nolan, 2005, p. 18). He delineates two reasons for the use of verbal processing in music therapy practice:

1. For the client "... to increase awareness or understanding about internal (thoughts, observations, and feelings) and external events (within the music and interpersonal areas of experience)" and
2. to "... provide the therapist with a way to gather additional information." (Nolan, 2005, p. 18)

Nolan states:

> As a result of verbal processing, the client and the therapist are able to re-enter into the musical experience (expressive or receptive) with new insights and a more developed therapeutic alliance (2005, p. 18).

Nolan advocates the use of verbal processing to enhance:

- awareness about the music, including aesthetic aspects

- awareness of the client's musical behavior
- awareness of interpersonal processes in the music, including musical roles
- awareness of inner emotional or cognitive experiences during music

One particular statement stands out: the awareness of the relationship between the "musically experienced self" and the "verbally experienced self" (p. 22). The therapist who can talk about the music experience in musical terms, as suggested by Gardstrom, would have the verbal skills necessary for this clinical goal. Nolan proposes that verbal processing can then help the client toward greater integration of verbal and nonverbal self—"... the client may, as a result, more fully experience changes in thinking or feeling" (p. 23). Later, the therapist can use verbal processing to move the client from the music/therapeutic state to the more ordinary state needed to reenter everyday life.

Words also serve to codify and relay information. Nolan says that gathering information about the client is the second purpose of verbal processing. The therapist may use the information for assessment, treatment evaluation, and interpretation. The interpretation might include confrontation as a verbal technique (pp. 23–24).

Gardstrom, Borczon, and Nolan all discuss silence in music therapy within the topic of verbal processing. All see the deliberate use of silence by the music therapist as a valuable clinical technique, both in the music and in verbal discourse. Borczon says that silence can create space, breath, rest, anticipation, release, and tension (2004, p. 56). Both he and Nolan recommend that silence be a place for both the client and the therapist to breathe, reflect, and determine how to proceed in the therapy. Both also hint that the appropriate use of silence might be one of the hardest verbal techniques for new or young music therapists. Silence will be one of the techniques explored further in later chapters.

In addition to the scarcity of literature on the use of and training in verbal skills for music therapists, there also appears

to be significant challenges with outcome research into verbalization within music therapy. The earlier articles by Wolfe et al. and Amir provided direction on how and why experienced music therapists were using Verbal Interactions and verbal processing but did not look objectively at the outcomes when including word-based interventions in music therapy.

A 2015 article by Pitts and Silverman in the *Journal of Creativity in Mental Health* attempted to isolate verbal processing in music therapy sessions to study whether verbal techniques had any effect on coping and leisure skills for psychiatric patients (2015, p. 184). However, the article did not identify or define verbal processing and gave no information on verbal processing techniques or implementation.

Silverman returns to the subject in other articles on music therapy in mental health and in his 2015 book *Music Therapy in Mental Health for Illness Management and Recovery*. In this volume, he anecdotally connects verbal and music therapy interventions to the 1955 analysis by Corsini and Rosenberg of basic therapeutic change mechanisms in verbal therapy—cognitive factors: universalization, insight, and modeling; affective factors: acceptance, altruism, and transference; and behavioral factors: reality testing, ventilation, and interaction (Corsini & Rosenberg, 1955, p. 407; Silverman, 2015, pp. 108–114).

This listing is similar to the widely used *Eleven Therapeutic Factors* proposed by Irvin Yalom (2005) for group psychotherapy: instillation of hope; universality; imparting information; altruism; the corrective recapitulation of the primary family group; development of socializing techniques; imitative behaviors; interpersonal learning; group cohesiveness; catharsis; and existential factors (Yalom, 2005, pp. 1–2).

A different type of research into verbal skills in music therapy was published in 2016 by Katarina Lindblad. Her hermeneutical analysis discovered that the participant therapists used a number of different Verbal Interventions, including questions, repetition, and other types of commenting phrases; silence; educational comments; paradoxes and rephrasings; symbolic language; interpretations; and dialogue about the musical content. She identified three functions of

verbal language as used by the participants: "to establish trust in order to bring about a genuine encounter, to deepen the experience of the present moment, and to clarify the client's life story" (Lindblad, 2016).

Across the board, the authors cited in this chapter call for greater understanding and training of verbal skills in music therapy. Author Lori Gooding was no exception, but she offered a model to help in the preparation of young music therapy students through microskills training, which is a systematic process used to develop counseling skills that includes theoretical orientation, modeling, practice, and feedback (Gooding, 2017). She suggests that this process could be implemented in music therapy education to develop culturally and ethically sensitive practices. Gooding's proposed process moves students from basic to more complex skills, beginning with attending, empathy, and observation skills, then moving to basic listening skills, then on to influencing skills, and then to skill integration.

So far, we have traveled a journey through the history of music therapy in search of guidance on the meaning and use of verbalization in music therapy to help us develop basic verbal skills. There will undoubtedly be much more written as the field grows and advances. The last word for now will be given to Kenneth Aigen, who circles us back to the deeper issues surrounding music and words posed in the beginning of this chapter. In *The Study of Music Therapy: Current Issues and Concepts*, Aigen (2014) writes:

> The drive to use verbalization in music therapy cannot be separated from the debate over whether music in music therapy is only a means to a nonmusical end or, alternatively, is it a legitimate medium of experience (p. 106).

All of the thoughts and ideas presented in this literature review will be gratefully used in the coming chapters to create a guide for the young professional or student as they move toward more meaningful, effective, and ethical use of

verbalization within their practice. This work is not meant to supplant these efforts of early writers but to synthesize and build on them in a format that can be easily digested by beginning therapists. It is hoped, though, that the complex issues underlying the use of words and music, or words versus music, will continue to inform each therapeutic interaction so that decisions to use one, or the other, or both will be driven by the best interests of the client.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Take the time to read the entire writings that are synthesized above. Journal or reflect on which of the authors are most closely aligned with your manner of music therapy practice.
- Journal or reflect on the concept stated frequently in this chapter that the interventions chosen by the therapist should be driven by the needs of the client.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Many of the authors cited in this chapter give very specific and detailed guidance on how and why words could be used in music therapy. Create a chart or easily used list of these items to have as a handy reference in your clinical space.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Your direct supervisor (not a music therapist) observed one of your sessions in which more than half of the time was spent in verbal conversation with the client. Using

the ideas and direct quotes of one of the authors from the chapter, explain to your supervisor how your use of Verbal Interventions is supported in music therapy literature.

Chapter 3

WORDS AND MUSIC IN MUSIC THERAPY SCOPE OF PRACTICE

Before deciding to use words, music, or both as an intervention, it is vital to understand the ethical, professional, and legal restrictions that regulate therapeutic practice. In many locations where music therapists work, professional organizations and governmental agencies have sought to define and limit practice boundaries. These limitations are generally put in place to protect clients but may also serve as a way to create a clear, professional scope of practice.

As seen in the literature review, the line between using music or words in therapy is not always a neat one. Music therapists often overlap with other disciplines when it comes to using music or words. Speech therapists, occupational therapists, recreation therapists, sound healers, and some mental health practitioners might use music in their work. Psychotherapists, mental health counselors, psychoanalysts, marriage and family therapists, and social workers generally use verbal interventions in the same way that some music therapists do.

In the United States, the American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT) have issued a joint Scope of Practice document (https://www.musictherapy.org/about/scope_of_music_therapy_practice/) that states:

> The music therapy interventions may include music improvisation, receptive music listening, songwriting, lyric discussion, music and imagery, singing, music performance, learning through music, music

> combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. (2015)

It can be assumed that verbalizations would be part of several of these listed interventions, such as lyric discussion and music and imagery.

The American Music Therapy Association (AMTA) also refers to verbalization in both the Professional and Advanced Competencies that determine practice proficiency.

- American Music Therapy Association Professional Competencies (https://www.musictherapy.org/about/competencies/)
  - C 13.3 Provide verbal and nonverbal directions and cues necessary for successful client participation.
  - C 13.5 Utilize therapeutic verbal skills in music therapy sessions.
  - C 13.6 Provide feedback on, reflect, rephrase, and translate the client's communications.
  - C 16.4 Inform and prepare the client for approaching termination from music therapy. (2013)
- American Music Therapy Association Advanced Competencies (https://www.musictherapy.org/members/advancedcomp/)
  - B 4.7 Utilize advanced music therapy methods within one or more theoretical frameworks to assess and evaluate clients' strengths, needs and progress.
  - B 4.10 Utilize advanced verbal and nonverbal interpersonal skills within a music therapy context. (2015)

The AMTA/CBMT Scope of Practice document also acknowledges that both music interventions and verbal interventions have the potential for client harm and cautions all practitioners (https://www.musictherapy.org/about/scope_of_music_therapy_practice/):

> The scope of music therapy practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music intervention or experience, but rather a continuum of skill sets (simple to complex) that make the profession unique. (2015)

The AMTA/CBMT statement on the continuum of skill sets from simple to complex in music therapy practice is very pertinent to the discussion in this book on the use of verbalization. A more detailed exploration into levels of music therapy practice will be covered in the following chapter.

A number of other professionals working in healthcare, education, rehabilitation, and wellness use verbal interventions in their work. Professions such as psychology, psychiatry, and mental health counseling include psychotherapy and verbalization within their treatment protocol. The National Institute of Mental Health (NIMH) states:

> Psychotherapy (sometimes called "talk therapy") is a term for a variety of treatment techniques that aim to help a person identify and change troubling emotions, thoughts, and behavior. Most psychotherapy takes place with a licensed and trained mental health care professional and a patient meeting one on one or with other patients in a group setting. (retrieved in 2019 from https://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml)

Most of the professions that use psychotherapy (or talk therapy) are currently licensed in much of the United States. Since the practice of these professions is regulated, there is often a misperception that psychotherapy is regulated. This has only happened to this date in New York State, with the passage of the 2002 Mental Health Practitioners Law. Fortunately, music therapists have the opportunity to be licensed as creative arts

therapists under this law. Creative arts therapy is significant, since the definition under this law states that treatment is "through the use of the arts" and "mental health counseling and psychotherapy" (http://www.op.nysed.gov/prof/mhp/article163.htm).

Regulation of professions is a state-by-state responsibility in the United States, making the discussion of verbal interventions, psychotherapy, and music therapy in scope of practice complex. In a number of states, opposition to music therapy regulatory recognition has been strong from traditional professions that use verbalization such as psychology and counseling. The challenges have centered on both the use of music by other professions and the use of verbal psychotherapy by music therapists. The American Music Therapy Association and the Certification Board for Music Therapists continue to advocate and educate legislators and clients on these issues.

In recent years, the American Speech-Language-Hearing Association (ASHA) has been particularly vocal about the infringement on their identified scope of practice by music therapists. Although not specific to the use of Verbal Interactions in therapy, ASHA does warn their members that "... music therapists are not subject to the same rigorous qualification standards and do not acquire the skills necessary to assess and treat communication disorders" (retrieved in 2019 from https://www.asha.org/ Advocacy/ Music-Therapy-Talking-Points).

A number of states have seen opposition to music therapy occupational regulations by ASHA. A sample opposition letter sent out in 2016 states, "We are concerned that there may be unlicensed practice in the areas of speech-language pathology, audiology, occupational therapy, physical therapy, and counseling, among others. It is stated that music therapists cannot diagnose communication disorders but does not ban the treatment of such disorders. As stated above, such treatments are within the scope of uniquely trained speech-language pathologists" (retrieved in 2019 from https:// www.asha.org/uploadedfiles/HT-Music-Therapy-Sample-Letter.pdf).

The ethical music therapy practitioner has the responsibility to know and understand the practice regulations

in their state or region to determine whether the use of Verbal Interventions is regulated. Ethical practice also deems that each clinician should thoroughly know and understand their professional scope of practice.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Contact the AMTA, CBMT, your state board for occupational regulations, or your professional music therapy organization to find out regulatory guidelines for practice in your region.
- Ask specifically about any prohibitions on the use of Verbal Interventions or focus on treating communication deficits.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Read and study the music therapy scope of practice as defined by your professional or certifying organization.
- Create two or three sample phrases that you can use to explain how verbalization fits into your defined scope of practice. Use statements from the literature review in the previous chapter to help you. An example might be "I use verbal reflections of feelings/music to help my clients better understand the music therapy experience." (Borczon, 2004)

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- You are employed as a music therapist within the mental health program of a local agency working with at-risk youth. A new psychologist has just been hired and has

expressed his concerns that when you lead group discussions, you are crossing professional boundaries and infringing on his job. Prepare a short statement that you can use in a meeting with him to explain music therapy scope of practice and how you are acting within your scope when using verbalization in your sessions.

Chapter 4

WORDS IN MUSIC THERAPY LEVELS OF PRACTICE

Music therapy education and training, as well as music therapy practice, are varied and diverse. Creating some kind of organization to understand its wide-ranging nature is helpful to funding agencies, regulatory bodies, professionals, and most important, clients. Our clients especially deserve to know what kind of help and what kind of treatment they can expect when seeking our professional services. Many professions have clearly established levels that are supported both in practice and in policy. One easy example is medicine. Each level of treatment has a codified scope as well as level of practice. If you have a health concern, you would choose the level that best fits your needs. Maybe you require help only with daily living needs as you recuperate from an illness. In this case, a home health aide or nursing assistant would be a good choice. Need medication administered or bandages and dressings changed? A nurse would do that. General checkups for health and wellness? Your primary care physician's office is the place to go. More complicated prescriptions or diagnosis? You would find a doctor who specializes in that area of health. Require surgery or a very specific treatment protocol? A board-certified medical specialist would be your best bet.

Again, you might be questioning what any of this has to do with verbal skills. Let's stretch the analogy above to make some comparisons. If the medical care you need requires only the most basic level of service, such as from a home health aide, you can expect the treatment to involve daily functional activities. He or she would help you tie your shoes or organize your medications in a pillbox. All very necessary, but auxiliary

to the main problem. At the other end of the spectrum, your health challenges might be extremely complex, with the need for an in-depth investigation into causes and treatments. Your medical professional would need very sophisticated tools and extensive training in their use.

Something similar can happen in music therapy. Working at an auxiliary level (Bruscia, 2014, p. 207), a music therapist could arrange for a local band to come and perform. The therapist's use of words might be designed to help a client find appropriate seating or explain what kind of music to expect from the program. The other extreme would be a music therapist working in Bruscia's primary level (Bruscia, 2014, p. 209). This level of practice requires both depth and breadth. The music as well as the words and dialogue used would aim to explore, uncover, and confront complex and intricate challenges faced by the client. The verbal as well as musical skills would require sophisticated and specific skills and knowledge.

Music therapy associations as well as music therapy scholars have been moving toward a clearer and more understandable picture of the profession's levels of practice. The American Music Therapy Association (AMTA) currently has two official levels of practice: professional and advanced. These were briefly discussed in the previous chapter. Differences in verbal skills for each level are not completely spelled out but can be inferred. In the professional level of practice, words are used to give directions or cues; to provide feedback or to reflect, rephrase, or translate the client's communication; or to inform (https://www.musictherapy.org/about/competencies/). In the Advanced Competencies that outline advanced levels of practice, the document simply refers back to utilizing advanced music therapy methods and advanced verbal interpersonal skills (https:// www.musictherapy.org/ members/ advancedcomp/).

Unlike with the levels identified by AMTA, several writers have been very clear about the use of verbal skills in varying levels of music therapy work. Wheeler (1983) outlines three levels, with the purpose and use of verbal skills in each. The key

points to highlight are made clearer in the table below (Wheeler, 1983, pp. 9–11).

Table 1
Wheeler's Three Levels of Verbal Skills (1983)

Description of Level	**Use of Words**
Music Therapy as an Activity Therapy	* Verbalization about the activity * Minimal discussion of other related feelings * Include advice and information-giving * Reassurance
Insight Music Therapy with Re-educative Goals	* Verbalization plays an increasingly important role in the therapeutic process * Exposition and discussion of feelings, which lead to insight are used * "The goal of both the musical and the verbal aspects of the session is to help individuals examine the ways in which they relate to other people and to their individual selves." * The music is frequently used as a stimulus for verbalization * The thrust of the therapy is toward the insight achieved through discussion
Insight Music Therapy with Reconstructive Goals	* Verbal discussion of previously unconscious material * Must have advanced clinical training and be thoroughly aware of individual dynamics and psychopathology

Bruscia has written extensively about levels of practice in music therapy. References to the use of verbalization and verbal processing are embedded throughout the work. Bruscia explains that "[a] level describes the breadth, depth, and significance of the therapy process and the changes

accomplished therein, which in turn reflect the level of training needed by the therapist" (Bruscia, 2014, p. 205). He identifies four main levels within current practice:

- *Auxiliary level.* The Auxiliary level includes any practice that has musical or nonmusical goals that are not health-related but beneficial nonetheless. The practice does not qualify as therapy, either in goal, content, method, or relationship between provider and consumer.
- *Augmentative level.* The Augmentative level includes any practice in which music or music therapy is used to enhance the efforts of other treatment modalities and to make supportive contributions to the client's health.
- *Intensive level.* The Intensive level includes any practice in which music therapy takes a significant role in addressing the priority health needs of the client and makes significant changes in the client's current situation.
- *Primary level.* At the Primary level, music therapy takes an indispensable or singular role in meeting the main therapeutic needs of the client and makes pervasive changes in the client's health and the client's life. (Bruscia, 2014, pp. 207–209)

In each level, the use of words in the music therapy context is directly tied to the goals and aim of the therapy. In the example above, a music therapist working at the Auxiliary level would use words to direct and inform, but not treat. When providing services at the Augmentative level, the music therapist might use verbal skills to focus attention toward the music or to comment on responses and behaviors related to the music-making. This could be a verbal observation such as "It was so exciting to hear how everyone synchronized their drum-beating" or an open-ended question like "What did you think about the way we all played that song?" Notice that the words are directly tied to actions and thoughts about the music experience.

As a therapist moves into the Intensive level, the words become part of an interactive dialogue in which the client and therapist move beyond the immediate music experience to connect feelings and thoughts with the music-making. As the therapist, you might say, "I noticed that your instrument play didn't seem to fit with the rest of the group. Is not fitting into a group activity something that happens to you in other places?" Here, the therapist uses words to open the door to a conversation linking music responses to challenges the client might be having in other parts of their life. At the Primary level, the music therapist engages the client in verbal processing to uncover, explore, and confront deep issues that were played out in the music experience. As stated before, the use of verbal processing in the Primary level requires advanced training and expertise.

As a music therapist or music therapy student, you have an ethical responsibility to know at which level you are competent to practice. This competency is developed through education, training, and experience. Competency is most often formally recognized through meeting the standards of professional or certifying bodies. However, you might not always be allowed to work at your level of expertise. Each facility or funding agency (such as a hospital, nursing home, or school) has the right to outline the level of treatment that is provided to their clients or patients. This is most often reflected in the job description or job title. A music therapist might have the expertise to function at the Intensive level of practice but be hired under the title and scope of practice of "Recreation." In this case, the use of Verbal Interactions should reflect the Auxiliary level as defined by Bruscia. As an example, when working under the recreation scope of practice, music therapists should not be engaging in Verbal Interventions designed to treat the patient. This is a frustrating situation for many professionals. The ethical response for a person who is qualified and wants to engage in more depth work is to educate the agency and work to change the job description as well as title.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Read the original documents on levels of practice in music therapy as presented above. From your reading and the summary, reflect and journal on the following questions:
  - Which of the levels of practice in music therapy did my education prepare me for?
  - Which of the levels of practice in music therapy did my training prepare me for?
  - Which of the levels of practice in music therapy did my experience prepare me for?
- Survey your workplace administration and protocol to reflect on the following questions:
  - Which music therapy level of practice best fits the stated mission of my workplace?
  - Which music therapy level of practice best fits the administrative expectations of my workplace?
  - Which music therapy level of practice best fits the common practices in my workplace?
  - Which music therapy level of practice best fits the client expectations in my workplace?
  - Does my state prohibit me from working in any of the four levels of music therapy practice at my workplace?
- Compare your answers from the two different sections above. Write a short narrative comparing your view or your level of practice with the expectations from your workplace.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Many music therapists work in multiple levels of practice, depending on work requirements and client needs. Write a short paragraph explaining how your

perceived level of music therapy practice is aligned (or not) with your workplace requirements.

- Write a list of two or three sample sentences (such as the ones in this chapter) that illustrate how you use verbalization within the current level of practice most frequently found in your work.
- Write a list of two or three sample sentences (such as the ones in this chapter) that illustrate how you would use verbalization within the level of practice that you are qualified to work in but not employing in your current work.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Your home state has recently allowed for the licensing of music therapists in mental health treatment. Up to this point at work, you have been required only to provide group sing-alongs and other recreational events. Your boss is open to changes in your job title and scope of practice to incorporate this new professional recognition. Write a narrative or script for your meeting with her explaining the music therapy levels of practice and how you would use both music and verbal interventions to meet client needs at the Augmentative or Intensive level.

Chapter 5

WORDS AND MUSIC AS AGENTS OF CHANGE

The influence of music therapy theory on verbalization in therapy is a subtle theme running through the prior chapters. How and why we think music therapy works is directly connected to how and why we think people work or how music or words work. The previously examined levels and scope of practice specify external regulatory boundaries, but the decision on which theoretical orientation drives your work is yours to make. Theoretical framework most often determines clinical choices and is a critical consideration when deciding to use words, music, or both. Choi (2008) researched the intersection of practice and theoretical approaches and found that "... many music therapists base their current practice on their previous schooling and practicing areas, along with their age groups and academic degrees" (p. 103). The article implies that students may not have the background to choose a personal theoretical approach and will tend to adopt in practice what they learned in their education. It might also be that new practitioners are using learned verbal strategies and techniques aligned with the theoretical orientation taught in their academic setting. New professionals might be using verbalization in sessions without fully examining the purpose or function of words in their current setting. Critical reflection on your thinking about music therapy theory, then, is an important facet in deciding how, when, and why to use words in your work. Bruscia explains theory in this way:

> A theory is a set of interrelated principles or constructs that have been created by a theorist to

> describe, organize, explain, and explicate empirical facts and phenomena within a particular domain and thereby provide a conceptual framework for decision-making (Bruscia, 2014, p. 202).

A number of different ways to categorize music therapy theory and approaches have been proposed. Wigram et al. suggest two main schools of therapeutic thought: behavioral and psychoanalytical/psychotherapeutic (2002, p. 61). Wheeler, in the *Music Therapy Handbook* (2016), includes chapters on psychodynamic, humanistic, cognitive-behavioral, developmental, neurologic, community, and expressive arts approaches and orientations. Aigen (2014) broadens the list of orientations in current use: field of play, biomedical, neurological, culture-centered, aesthetic, community, complexity-based, music-centered, analogy-based, dialogical, feminist, resource-oriented, and humanities-oriented (p. 220). Bruscia (2014) groups theory, research, and professional practice together in articulating a number of current music therapy practices: didactic, medical, healing, psychotherapeutic, recreational, and ecological. All of these discrete areas have distinct methods (including verbalization) that fit into practice and support theory.

Theory is also closely related to music therapy models of practice. A model is a defined set of methods and practices supported by specific theory and research. Most models were created by an individual therapist or group of therapists. Some of the more widely known models of practice include: Aesthetic Music Therapy, the Alvin Model, Analytical Music Therapy, the Benenzon Model, Biomedical Music Therapy, Bonny Method of Guided Imagery and Music, Community Music Therapy, Culture-Centered Music Therapy, Environmental Music Therapy, Feminist Music Therapy, Interactive Family Music Therapy, Multimodal Psychiatric Music Therapy, Neurologic Music Therapy, Nordoff-Robbins Music Therapy, Orff Music Therapy, Resource-Oriented Music Therapy, and Vocal Psychotherapy (Kirkland, 2013). Descriptions of these and many more music therapy models can be found in the third edition of Bruscia's *Defining Music*

Therapy (2014). As already explored, some music therapy models rely on music-centered interventions, some rely on Verbal Interventions, and some on both. All include the possibility of verbal communication, and all require some level of basic verbal skill on the part of the therapist.

The still-evolving nature of music therapy theory, and perhaps the ever-increasing number of models, led Kenneth Bruscia to propose a new way of framing the discipline of music therapy: integral thinking. Bruscia challenges clinicians, educators, theorists, and researchers to "... accept the reality that there will always be differences of opinion about practice, theory, and research and that these differences are essential to the growth of the discipline" (2014, p. 252). He proposes six changes to be considered for integral thinking: integrate new and old; see differences as options; respect the ideas of others; be reflexive; continually change locus and focus; and consider micro and macro perspectives (2014, pp. 251–259).

One way to incorporate Bruscia's concept of integral thinking into verbalization in music therapy work is to apply the six principles from above. Coming full circle from the word versus music divide noted in the early days of music therapy, this way of thinking can allow you to make mindful and informed decisions on which mode of communication will best meet the moment-to-moment needs of your client in a flexible and reflexive manner. Again, quoting Bruscia:

> Thus, music can be the focus with verbal discourse as facilitative; music and verbal discourse can be used in tandem; and verbal discourse can be the focus with music as facilitative. Once again, these ways of working may shift from one experience to another or from one session to another. (Bruscia, 2014, p. 46)

Rather than dwelling further on varying theories or specific models (both way beyond the scope of this book), we will now move toward more integral thinking through examining a central principle that runs through both theory and models: the agent of change.

What is the agent of change in music therapy? Is it within the moment of musicing that your client engages most fully in the therapeutic process? Is this when change happens? Is it in anticipation of the musicing, creating the opportunity for a change in behaviors or responses prior to the music experience in order to engage in music? Or is it in the reflection on the musicing process, either through thought or verbal discussion that is the primary agent? The answer to these questions can be considered through both micro and macro perspectives as suggested by Bruscia. Your answers will have broad implications for your overall approach to practice as well as have a very narrow and specific impact on your clinical decisions. This is particularly important in deciding to use words or not use words within therapy.

In this way of thinking about the agent of change, music is still a central component. The precise process of change, though, shifts. Words and music are used in very different ways. The clinical meaning of each changes in both therapeutic focus and delivery. The three views of the agent of change can be summarized this way:

Anticipating the Music

The client makes changes in behavior, thought, or action in anticipation of entering the music experience. The therapist uses words or gestures to inform or direct the client toward targeted change leading into the music experience. It is the anticipation of the music experience that becomes the agent of change for the client. Most often, words and spoken language are the technique of choice in this way of thinking.

Musicing

The client makes changes in behavior, thought, or action within the musicing. The therapist provides music strategies and techniques designed to allow the opportunity for the targeted area of change within the music-making. The agent of change is the musicing itself. Words or spoken language are used to facilitate the musicing.

Processing the Music
The client makes changes in behavior, thought, or action after processing the music experiences. The therapist uses words and verbal discussion to allow the opportunity for insight into targeted area of change. The agent of change is reflection and processing through verbal dialogue after the music. The use of verbal dialogue and discussion is the primary technique.

It might be helpful at this time to reflect deeply on a small moment from a music therapy session. Think about the specific needs of the client in that moment. Which therapeutic technique will provide the most optimal opportunity for therapeutic change for the client in that very small slice of time? Music? Words? While your macro view might be that music should be the predominant choice, in that particular moment your client might find words to be the most powerful agent of change. On the other hand, you might be certain that only words can create the chance for lasting change for the client. But in that moment, music might transform the client in the most meaningful way. Determining the primary agent of change within therapy can lead us into a clearer understanding of when and why to use words. As seen above, words are used in all three views but in vastly different ways. Incorporating all of these different ways to use words in practice requires a broad and integral way of thinking about verbalization in music therapy. Being mindful of the agent of change in music therapy practice, then, requires a flexible and fluid openness to providing the client with the clinical experience that the client needs in the moment.

When thinking about using words in a more integral way in music therapy, it is helpful to group the use of verbalization into four categories: Verbal Framing, Verbal Exchanges, Verbal Interactions, and Verbal Interventions. These categories delineate the use of words by the function they serve within music therapy and guide the therapist into how to use verbalization for the benefit of the client within the determined agent of change and with respect to scope and level of practice.

Verbal Framing

Words and verbalization are used by the therapist to direct, guide, or inform the client. Spoken language is simple, clear, and concrete and focuses on the immediate environment and circumstances. No verbal response is expected of the client.

Verbal Exchanges

The therapist and client engage in reciprocal verbalization focused on the simple exchange of information or response to directions or guidance. The focus of the words and language is on the immediate environment or circumstances.

Verbal Interactions

The therapist and client engage in reciprocal verbalization with the intent to create or sustain therapeutic relationships, share meaningful information about the music experience, communicate social and emotional content related to the music, or provide feedback which reflects on the rephrasing or translation of communication or responses in the session. The words and language focus on conscious material presented by the client in the immediate environment and circumstance. Verbal Interactions generally lead back into the music-making to resolve therapeutic issues but could move to Verbal Interventions if appropriate.

Verbal Interventions

Words and language are used as the primary agent of change by both the therapist and client. Verbalization is designed to process, uncover, explore, and confront therapeutic issues leading to client insight. Verbal Interventions include discussion of immediate experiences as well as conscious and unconscious material brought into the session by either the client or the therapist.

All four categories might be used in a single session or throughout treatment. Each category has a place in the music therapy context. However, every therapist should use caution and be mindful of how their education, training, and experience have prepared them with the skills to work within the chosen category. Each category will be further defined and explored in later chapters, with specific language and examples given to provide more in-depth understanding and practice.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Explore your educational and training experiences and think about how these experiences influenced your understanding of music therapy theory. How did this affect your view of the use of words in music therapy practice?
- Use reflection or journaling to examine your current theoretical framework for practice. How has it changed or stayed the same? What is the impact of this theory on your view of verbalization in music therapy practice?

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Words are used in this chapter to organize concepts within music therapy practice. What words would you choose to describe how you think about the use of music in your therapy practice? What words would you choose to describe how you think about the use of words in your therapy practice?
- How are your choices of word descriptors different from the ones used by the authors cited in this chapter?

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- You are attending a music therapy conference with students and professionals of various backgrounds. Practice a persuasive argument to support each of the views of the agent of change (Anticipating the Music, Musicing, Processing the Music) mentioned in this chapter to use when discussing music therapy with your colleagues.

Chapter 6

Client Needs and Verbalization in Music Therapy

Earlier chapters have given an overview of the guidelines and regulations for practice within music therapy which impact the use of verbal skills. These guidelines and regulations are primarily put into place to protect clients and assure appropriate and effective treatments. As music therapists, we work hard to guarantee that our music interventions are appropriate and effective. However, the client and client needs are the most important factors when planning treatment. This includes determining why, how, or when to employ verbal skills. An inclusive view of incorporating verbalization in music therapy to meet client needs is supported by most if not all of the literature on the use of words.

We also have examined how verbalization is used in very different ways, depending on the levels of music therapy practice and theoretical context within which the therapist operates. Words can be the primary agent of change, together with music as the agent of change, or in support of music as the agent of change. Music therapists can and do work in each of these different but equally valuable ways of thinking. However, in his examination of verbalization in music therapy, Aigen cautions: "Clients are the most significant stakeholders in the process, and they do not have a vested interest in any particular clinical framework" (Aigen, 2014, p. 98). When making decisions on Verbal Interactions or Interventions, client benefit must come before therapist conviction.

Why and when do our clients need words? The proposed organization of the use of words in music therapy in the previous chapter can help to answer that question. The four

basic categories—Verbal Framing, Verbal Exchanges, Verbal Interactions, and Verbal Interventions—were designed to help you match your level of verbalization with the needs of the client. All four categories can be clinically useful but are highly dependent on individual treatment circumstances. Each is related to the place of music within the treatment.

The use of Verbal Framing and Verbal Exchanges are included within most music therapy sessions. Verbalization within these categories can be helpful to orient the client toward the music and music therapy and inform them about the experiences that can be expected. Verbal Exchanges can also provide pertinent assessment details for the therapist, leading to more effective treatment. All clients can benefit from the practical and logistical instructions and information-gathering that words can accomplish. For clients whose needs can be best treated in the music, this use of verbalization can lead quickly and effectively into the musicing.

Verbal Interactions are also very frequent in practice. Client benefits include creating and sustaining the therapeutic relationship, sharing meaningful personal information, and communicating social and emotional content. Verbal Interactions can also help the client by clarifying the client experience and guiding the client's progression in the music through words. Verbal Interactions are flexible and can lead either into the musicing or into verbal processing. With Verbal Interactions, the client can show the therapist the mode of communication that might be most therapeutically effective in the moment. This could point the therapist toward using Verbal Interventions for greater cognitive or linguistic depth or direct the process toward and into the music.

Verbal Interventions require that the client both has the capability to use words and spoken language and consents to using verbalization as a primary agent of change. In his discussion of the use of music in therapy or use of music as therapy, Bruscia outlines a clear way for the music therapist to determine whether to use Verbal Interventions to meet client needs (Bruscia, 1987, pp. 503–504). To reinterpret his thinking to aid with decisions on the use of words as the primary agent

of change in music therapy, consider the following:

- Use Verbal Interventions when the client ...
  - Is not accessible to music interventions,
  - Needs and wants to verbalize insight and is ready to do so,
  - Needs and wants to resolve problems through verbal as well as musical means, and
  - Can achieve therapeutic growth more directly through the use of Verbal Interventions.

Verbal Interventions are most often used to cognitively and linguistically process the challenges on which the client agrees to work in music therapy. Using Verbal Interventions does not preclude moving into and out of the music freely. Most of the literature on verbalization within music therapy has focused on techniques for Verbal Interventions (Amir, Bruscia, Gardstrom, Nolan). These techniques will be covered in future chapters, but with the caution that the client is the most important determiner on whether to engage in this level of therapy. To summarize:

- Verbal Framing directs the client into musicing.
- Verbal Exchanges support and guide the client into musicing or toward Verbal Interactions.
- Verbal Interactions could lead the client to musicing or could move the client into Verbal Interventions.
- Verbal Interventions can be sufficient for effective treatment or allow the client the choice of when and how to move back into musicing.

Is there ever a time when verbalization is contraindicated for particular clients? Can the use of words and language actually be therapeutically harmful? In examining verbalization in therapy, the ethical music therapist should not only think about the most effective treatment for the client needs but also reflect more broadly on whether using words could be detrimental. Let's look at some possible examples.

Therapists sometimes refer to a common warning: "Don't open the door if you are not ready to deal with what is behind it." It is possible for a music therapist to use verbalization with a client to open a door behind which lies something for which neither is prepared. A young music therapist could unthinkingly ask a leading question or make a comment during Verbal Interactions that moves the client to reveal details about themselves that the therapist has not been trained to handle. A simple example could happen in a session with elderly clients focused on singing familiar songs. An open-ended question such as, "How does that song make you feel?" might bring one client to respond, "My husband always hated me." If the therapist is unprepared to help the client process these feelings, she might hastily respond, "Oh, I am sure that he loved you" and then move on to another song. In this case, the therapist's verbalization could actually harm both the client and the client/therapist relationship, as well as diminish the emotional connections that the client was looking to express.

For some clients, words and spoken language function as a defense or deflection from relating to the therapist and others. In this case, the client might engage the therapist in a one-way conversation in which the words serve to keep the focus off the music and away from the therapeutic issues. The therapist might unwittingly be drawn into the details of client stories and reinforce the unhealthy use of words by the client. One illustration might be seen with a client who dominates the group discussion by telling stories with content unrelated to the music or the therapy. In this case, the therapist's engagement in unilateral Verbal Interactions might prolong the time in which the client avoids therapeutic tasks.

A third example is when there is a lack of congruence between the client's words and reality. This might happen for people experiencing psychosis or severe dementia. If the therapist does not recognize the disparity, he might engage the client in illusory verbal discussions focusing on the superficial meaning of the words rather than the communicative intent. For instance, a client in a mandated psychiatric unit might be anxiously reporting to the therapist that they have an important

business meeting that they must attend and will need to leave the music. If the therapist focuses on asking about the specifics of the meeting or the business, they will miss the chance to explore what could be the client's message that they want to escape from their present situation.

In each of these examples, it is the therapist's responsibility to recognize that verbalization might not be a productive or effective intervention at this moment for this client. In many cases, this type of clinical challenge comes about due to a lack of understanding on the part of the therapist about how and when to use verbal skills in therapy.

One last thought about how verbalization in music therapy can help or hinder the client comes from Daniel Stern, a leading authority on human development. Stern examined how infants develop a sense of self and wrote extensively on how words and language factor into growth and identity. Stern offers a clear warning about placing too much value on words:

> But in fact language is a double-edged sword. It also makes some parts of our experience less shareable with ourselves and with others. It drives a wedge between two simultaneous forms of interpersonal experience: as it is lived and as it is verbally represented (Stern, 1985, p. 162).

He goes on to say, "Language, then, causes a split in the experience of the self. It also moves relatedness onto the impersonal, abstract level intrinsic to language and away from the personal, immediate level intrinsic to the other domains of relatedness" (Stern, 1985, p. 163).

To meet the needs of our clients in the most effective manner, we need to respect the power of words and language as a therapeutic medium in the same way that we respect the power of music and use each intervention with detailed attention, purpose, and care.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Read the literature of Daniel Stern or others who have written about development of language. Reflect or journal on how language can represent the "self" or split the "self."
- Explore your own practice experiences and write about a time when a client brought material into the session that you felt unequipped to handle.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Reread the three examples above in which the use of verbalization could cause harm. Write sample sentences of how words could be used in each case for more effective therapeutic outcomes.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Mrs. G has been in music therapy with you for several months. Her daughter recognizes the importance of the music experiences you have provided but has encouraged you to talk more with her mom to uncover the source of her anxiety and depression. Write out your answer to Mrs. G's daughter about why or why not you feel Mrs. G would benefit from more verbal dialogue in sessions, given your level of experience, training, and practice.

Chapter 7

VERBAL SKILLS BASICS FOR MUSIC THERAPISTS

Chances are that you have spent more time in your life using words to communicate than music. Even with intense musical and music therapy education and training, most of us still operate in a linguistic world. Words tend to be our default. We think in words, we communicate with others through words, we learn through words. It might be a struggle to imagine a day without thinking, hearing, reading, or speaking words. Many if not most of us operate daily within a word-driven culture, yet we tend to devote minimal time to thinking about the foundations beneath the human drive to use words and spoken language.

An initial task in developing purposeful and effective verbal skills as music therapists is thus to examine four basic verbalization constructs: the connection between words, spoken language, and cognition; the critical nature of listening in verbal interchange; the place of words and language in social and cultural identity; and the complexity of determining communicative intent. There is a wealth of scholarly and theoretical literature written on all of these subjects. For the purpose of this book, we will examine these four areas from the view of the practical, clinical impact of each for the working music therapist.

WORDS, LANGUAGE, AND COGNITION

Despite reams of articles and books that continue to investigate the subject, it is safe to confidently state that there is a direct connection and correlation between spoken language and cognitive ability. Developing infants first begin to use sounds

as a communication tool. Crying, cooing, screaming, and yelling are all instinctual vocalizations that indicate the child's physical, sensory, or feeling state. Most adults will respond to the infant sounds with words or word-like sounds. Sometime during the first year, most children will begin to shape their vocalizations to match the words that they hear. Soon the child's growing ability to "think" leads to an understanding of the connection between the word-like sound and concrete objects or actions in the environment. A classic first word for children identifies their "mommy" or "daddy" through repetition of sounds such as "ma" or "da." The more the child connects the sound they are making to the person or object, the more we can assume the object or person becomes connected in their mind with the familiar sound. Thoughts connect to sounds (or words) and words (or recurring sounds) create and connect to thoughts.

As the child becomes cognitively more aware of complex actions and events in the environment, they begin to acquire the words to describe what they see and experience, moving their spoken language into the realm of abstract thought. Again, cognition and spoken language have a symbiotic relationship. As one area grows, so does the other. Words become part of an organizational framework (language and grammar) that also serves to organize thinking. Soon, the child is using words as symbols of both their inner and outer worlds. They learn that others in their environment also use words to narrate "self." Words then allow the child to recognize and understand the thoughts and feelings of others. They can use spoken language to create connections with others in which the flow of ideas and emotions can be mutually understood.

Words and thinking (or cognition) develop from the simple and concrete to the abstract or symbolic and complex. When deciding how to use words in music therapy, we need to assess how the cognitive level of our client impacts their ability to understand and use spoken language. Cognitive challenges can arise for a number of different reasons—developmental disability, neurological injury, dementia, pain, or alcohol and drug use. Some clients have specific cognitive differences that could possibly impact the use of spoken language. One example

might be encountered with clients on the autism spectrum. Words and language are sometimes recognized only within their explicit meaning rather than in the more complex way in which words are infused with implied or inferred meaning. The precision with which some autistic people use words and language might make it problematic to engage in highly symbolic verbalization such as is found in a Guided Imagery in Music model of music therapy. On the other hand, this detailed and meticulous way of using language might be connected to the extraordinary cognitive abilities some people with autism demonstrate in the music and science fields. Common diagnoses that might be erroneously identified as cognitive impairment are hearing loss, apraxia, aphasia, motor disorders such as Parkinson's, mental illness, and stroke.

When planning for verbalization in music therapy treatment, the complexity of the vocabulary, grammar, and syntax should be appropriate for the cognitive level of the client, from simple to complex. The categories of Verbal Framing, Verbal Exchanges, and Verbal Interactions can be used with clients of all cognitive levels as long as the therapist mindfully adjusts the complexity of the vocabulary, syntax, and grammar to fit the level of the client. All three categories can also be used to assist clients in increasing or expanding their use of language, moving carefully from concrete to abstract. Many examples will be explored in later chapters, but consider the following two scenarios.

- John has very limited cognitive abilities. Here is a sample of the language the therapist might use in each of the three categories:
  - Verbal Framing—John, here is a drum. Let's play.
  - Verbal Exchange—John, will you take my hand and help beat the drum?
  - Verbal Interaction—John, do you like the sound of this drum?
- Joan has moderate cognitive abilities. Here is a sample of the language the therapist might use in each of the three categories:

- Verbal Framing—I brought a conga drum for us to play today. It has a really deep resonance that I think makes a satisfying sound.
- Verbal Exchange—Would you like to play with these mallets, or would you prefer to use the palms of your hands?
- Verbal Interaction—I am wondering if you want to share what you think about the way the music, especially the rhythm, sounded to you.

Decisions on the complexity of verbalization to use should never be procedurally tied to specific populations or ages. Instead, the cognitive abilities of each individual client should be meaningfully assessed before using any words. Imagine, if you will, having an elderly grandmother in a nursing home. If the therapist makes the assumption that all elderly people have low cognition, then they might use verbalization such as that in the first scenario, resulting in a disrespectful and therapeutically unproductive use of words with your very sharp-minded relative. On the other hand, a Verbal Exchange such as that in the second scenario might serve only to confuse a patient who has limited cognition with its perhaps unfamiliar vocabulary (mallets, palms) as well as grammar (would you prefer ... ?).

In the category of Verbal Interventions, words and spoken language most often require complex symbolic or abstract thought on the part of the client. When employing words as the primary agent of change, as in the use of Verbal Interventions, the therapist needs to clearly assess cognitive ability. They are ethically required to make sure that the client is able to clearly understand and use both explicit and implicit word meanings in the verbal discussion. The client must also have the cognitive capacity to fully consent to a therapy that uses Verbal Interventions and a deeper level of insight therapy.

LISTENING

Listening is a key component in music therapy practice, regardless of whether music or Verbal Interventions are being

used. Listening carefully is a basic and extremely necessary skill for every music therapist. It would seem that music therapy education and training should prepare therapists to be particularly sensitive listeners. However, clients can often use words and spoken language in unconventional ways, challenging us to listen in flexible and creative ways. We as therapists may also not want to listen, either consciously or unconsciously, to what our clients want to say. This situation can be due to countertransference or to a lack of exposure to and experience with client circumstances that are vastly different from our own.

How do we learn to listen to our clients' words? First, it is important for you, as the music therapist, to examine how you use and understand verbalization in your everyday life. How is spoken language used in your family, your community, your culture, or your work setting? Do you listen first before responding? Do others listen to you? Do you make assumptions about what a person will say before they speak? Do people do this to you? Do you interrupt conversations? Do others interrupt you? Do you misunderstand what a person is trying to tell you? Do people tend to misunderstand you?

One problem that can arise in listening to others is that we might tend to interpret the content and meaning from our own fixed views. Sometimes, these views create bias in truly hearing what a client is trying to communicate. While this can also happen when listening to the music, the ubiquitous nature of words and language in identity development might lead a therapist to unconsciously limit the way in which they "hear" words. An instance of this could happen when there is a significant life experience gap between client and therapist. A therapist who grew up in a middle-class community with abundant resources might choose to not listen openly when a client from a deprived background begins to talk about poverty, hunger, or abuse. Countertransference that is not acknowledged by the therapist presents another occasion when the therapist's own issues result in a lack of accurate and open listening.

Learning to listen will require you to examine and reflect both on outer habits and behaviors and on intra- and

interpersonal issues. Some simple exercises to help get you started are below:

- Use mindfulness strategies, such as deep breathing or music, to clear your thoughts before attending a meeting. Focus on each speaker in turn, making every effort to eliminate formulating your own ideas until they finish speaking. After the meeting, try to recall their exact words.
- Find a place where you can stand or sit without having to interact. Practice focusing on sounds in the environment one at a time. After you finish, try to recall exactly what you heard.
- Join a group of friends or a family event. Sit on the outskirts and practice focusing on only one speaker at a time. Do not enter in the conversation yourself.
- Journal or reflect on how you listen and how you are listened to in your family, your work, your community.
- Turn off all sounds and electronic media. Sit as long as you can in the silence and practice listening.

Social and Cultural Identity

Spoken language is only one component of cultural and social identity, but it might be the most present and recognizable. As verbal skills grow, the child assimilates cultural and social expectations into the words heard and used. By adulthood, the meanings of words and language are often completely intertwined with a view of ourselves as part of a larger community or group.

Most if not all music therapists eventually encounter clients or clinical settings where the language used is different from their own. The distinctions are more than just the sound of words or the auditory patterns and inflections. Grammar and syntax are often not at all the same. Many cultures also use language in unique ways to communicate. The ethical music therapist, then, must recognize and respect these linguistic variations. They must study and learn how verbalization and

cultural/social meaning intersect in both the presentation of clinical challenges and the provision of treatment. The use of verbalization in therapy must value the place of words in the client's overall cultural and social identity.

An illustration of this could be easily seen in a patient group in a big city hospital. Frequently, there is a mixture of people from differing traditions. One client's cultural language practice might lead them to verbally express details of their life in uninhibited and frank words. Another client from a different cultural background might not join in the verbal discussion at all, believing that verbal disclosure is inappropriate. Certain words, such as "therapy," may trigger very different responses from clients, depending on how the term is construed in their home community.

The music therapy profession has recently moved to become more reflexive and sensitive to cultural and social implications in practice. Developing effective verbal skills requires that each music therapist examine presumptions having to do with words and language and work toward greater consideration of cultural and social differences when using verbal skills.

Determining Communicative Intent

Before we respond verbally to clients, we need to accurately infer meaning and intent from their words and language. No amount of practice in employing basic verbal skills will be effective if we cannot correctly determine the communicative purpose of our clients' words and language. Our verbal responses must match what our clients say or attempt to say in order to adequately meet their needs. The fourth construct—determining communicative intent—is dependent on sensitive listening, cultural and social responsiveness, and accommodations for the cognitive functioning of clients.

Some basic guidelines for determining intent are fairly straightforward and mirror finding communicative intent in our client's music.

- Listen.
- Adopt an open and flexible approach to assigning meaning.
- Consider cultural and social language traditions and respect differences with your own language tradition.
- Focus on key words and phrases, especially ones that are repeated or emphasized.
- Engage the client in determining if your understanding of their words is truthful.

And, finally, the last guideline: Make use of your music therapist's ear.

- Listen to the musical qualities infused in your client's words and language to "hear" implicit or unconscious meanings and messages:
  - The rise or fall of melodic inflection
  - The use of pitch range
  - Incongruent use of dynamics
  - Pressured or languid tempo
  - Unusual or unexpected articulation
  - Irregular structure or phrasing
  - Variations in timbre

A later chapter will examine the connection of these musical qualities to implied meaning and give more detailed exercises on how to hear the intent beyond the words.

Ethical Practice

There is one more area in the examination of verbal skills that is critical—ethical practice. In music therapy, the words and spoken language used by the therapist must:

- Respect the client.
- Appreciate the client's uniqueness and differences.
- Acknowledge client agency and independence.
- Allow for client choice.

- Fit the client's therapeutic needs.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- There were many examples in this chapter about what to do and what not to do with words. Reflect on times in your clinical work when you felt uncomfortable with the words you chose to use. Why was that?
- Write about your assessment procedures. How has the client's ability to use words or language influenced the findings of your assessment? Has there been a time when misunderstanding a client's unusual or unexpected use of language has influenced your findings?
- Read some of the thoughts about silence and listening by authors cited in the literature review chapter, particularly Borczon and Gardstrom.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Use the sample verbalizations in the section on language and cognition to write several other scenarios from events you've encountered in your own sessions.
- Compile a list of words that have different meanings in different cultural or social traditions.
- Reflect on words that you frequently use that might be misunderstood or misconstrued by others.
- Create a personal strategy to help you learn to consistently listen more deeply.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Your work brings you to a community program with clients of different cultural backgrounds, cognitive abilities, and therapeutic needs. The program has assigned several volunteers to assist you during your sessions. Give a brief explanation of the four constructs of basic verbal skills listed above to help these volunteers understand how their conversation with the clients can support the therapeutic experiences.

Chapter 8

VERBAL FRAMING

How many times have you walked through a doorway without realizing that it is the frame that actually provides the boundaries and borders that allow you to walk safely through? A door frame is designed to define and delineate the space within. The door frame supports the surrounding structure, protecting the integrity of the doorway entrance. This everyday object can help in understanding the value of Verbal Framing in music therapy. Verbal Framing supports and structures the therapeutic space and experience. It provides clear boundaries and borders so that we (therapist and client) can safely and quickly enter and exit.

Verbal Framing describes when words and verbalization are used by the therapist to direct, guide, or inform the client. Spoken language is simple, clear, and concrete and focuses on the immediate environment and circumstances. No verbal response is expected of the client. This concept might seem too simplistic to spend time on, but it is a rare music therapy session that does not have some Verbal Framing. As you walk into a hospital room, you might simply state to the client, "I'm going to put the drum by the far chair so there is room for your wheelchair." In a special education classroom, there might be a more direct form of Verbal Framing that gives explicit instructions, "Susie, please put your book down and sit with me next to the piano." Notice that even these very simple sentences have respectful and collaborative language.

The simplicity and one-sided nature of Verbal Framing might make it seem unimportant or trivial, but the technique can be useful in all levels of practice. Even if the therapy will later move toward Verbal Interventions, the directness and clarity of framing can assist in moving the client more quickly

into therapeutic events. General guidelines for the use of Verbal Framing might include that ...

- The client or clinical environment requires verbal direction or guidance.
- The client is able to understand and process the verbal directions or guidance.
- The client's social or cultural background leads them to expect the use of words.
- The use of Verbal Framing supports greater client engagement in music interventions.
- Directions, information, or guidance will move the client more quickly to the therapeutic music experience.

As discussed earlier, the four categories of verbalization are a general way to organize your thinking about using words in music therapy. The following techniques outline specific clinical moments in which Verbal Framing is useful. It is important to remember, though, that in many of these moments, a visual, gestural, or music technique should also be considered and could be as useful or used in conjunction with words.

Creating the Image

Using words (along with visualization and music) to create the image is one way for the therapist to mindfully prepare prior to entering the client's space. Words and sentences are used to tell or remember the client's story, outline the client's attributes and strengths, articulate the client's need and goals, or review past clinical successes or challenges. You can use single words and phrases or a narrative style. The words can be spoken out loud, written down, or just held in thought. All this happens as you first prepare to enter the therapeutic space.

- Very fast drum, let's have some fun.
- Tense. Tight. Touch. Refrain. Reclaim. Release.
- Sue looked right at me last week when I started to play her favorite song. She has a very beautiful smile and the

wrinkles on her face all turn up when she smiles. I am going to help her find more music that will give her a sense of pleasure or contentment.

- I am thinking right now about Jeffrey and Jessica. I imagine that they will both come in the door together. I will play our running eighth note theme on the piano to greet them. They responded so excitedly to that music last week.

Initiating the Spoken Greeting

Expectations for music therapy are often established in the tiny fraction of a second when the client and the therapist first enter into proximity. You and the client become visually or auditorily present to each other in a defined space. In the next millisecond, either you or the client will indicate acknowledgement of the other. This can happen gesturally, perhaps with a wave, or through a look or smile. It can happen musically with a sung tone or harmonic strum on the guitar. Words or phrases used as initial acknowledgment are often termed a "greeting." For some new music therapists, deciding on which first spoken greeting to use can be confusing. As a general guideline, the verbal greeting should be respectful of the client's cognitive, cultural, social, educational, gender, or age background. It should reflect the client's relationship with the therapist. Many clients appreciate a greeting spoken in their native language. Some clinical situations also call for the therapist to use commonly accepted greetings customary to the facility. This could mean that in one nursing home, all clients are greeted by using an honorific followed by the last name—Mr. Smith or Ms. Reynolds. Some facilities address clients by their first names—Mary or John. Initial spoken greetings can be long or short, formal or informal, simple or complex. Just a few samples are below.

- Hi or Hello.
- Hey, Yo, or Howdy.
- How are you? How's it going? or What's up? What's new? are phrases not used as a meaningful question, but

as a greeting. Often the intonation of the phrase is slurred to make it sound like one word.

- Good morning, Mrs. Grant. Good afternoon, Mr. Simpson. Good evening, Flora.
- Good to see you. Nice to see you. Long time since I've seen you. Pleased to meet you.

The initial verbal acknowledgement or greeting is often followed by other forms of Verbal Framing, such as Setting the Tone, or by a move into Verbal Exchanges.

Setting the Tone

Immediately after the initial acknowledgement, most verbalization in therapy moves quickly into a phrase or sentence that sets the tone. As with all of spoken language, there is the explicit meaning set by the definition and cultural significance of the words, as well as an implicit meaning that can be communicated through pitch, melodic inflection, tempo, meter, and articulation. It is word meaning along with the musical qualities that set the tone. The tone can match the emotional or regulatory state of the client or provide a contrasting environment. Setting the Tone can also be accompanied by gestures or action.

- Happy to see you.
- I'm glad you came to music today.
- Wow, it is great to have you here!
- I see that everyone is here and ready. Looks like we're all set to make music today.
- Okay, let's get started.
- Let's get to it.
- Time to get to work.
- Ready?
- It seems as if we've all had a hard week. Maybe it would be good to take a deep breath.
- How about we sit in silence for a moment?
- Let me know when you would like to start.

Setting the Tone can also happen through planned silence.

Defining the Experience

Every client has the right to clearly understand what music therapy is and what they can expect from participating in music therapy. Words and spoken language are particularly effective for providing this information. While Defining the Experience is appropriate for everyone, the words and content of this verbalization technique will need to match the client's cognitive and language abilities. It is also particularly important for you, as the therapist, to succinctly and concisely define the music therapy experience for yourself before you can delineate it for your client. Again, we should be ready to use simple, concrete words as well as abstract, complex verbalization. Below are some samples of language. Be aware, though, that none of these samples will have the same impact for your client as using your own authentic words and ideas.

Some simple phrases:

- Music helps us learn lots of things.
- Playing music can give you a time to express yourself.
- We can listen to music together and talk about what it makes you think about.
- Here is some special music just for you that might help you relax.

More detailed language:

- We know that music can help with both short- and long-term memory. The music experiences we will have today are designed to help you with that.
- Music therapy can support the goals that you are working on in your rehabilitation program, such as range of motion and gait.
- Music often lets us express emotions in a way that we are not ready to express in words.
- It is often hard to be social when you are feeling so down. Making music with other people can give you the

opportunity to connect with others without having to explain yourself.
- Sharing a bit of yourself through music can be intimidating. The music that we will use today in therapy is here to support and encourage you.

For some clients, communicating a commonly accepted definition of music therapy might be the most appropriate way to Define the Experience. There are currently a variety of definitions of music therapy. It would be your responsibility as the therapist to clearly state the definition that most resonates with you and with your client.

Outlining Expectations

Just as clients need to know what to expect from music therapy, they also need to clearly understand what they will be expected to do in therapy. Many clients come to music therapy with little or no knowledge about the practice and even less experience with what being in this type of therapy means in terms of their participation. New music therapists sometimes get caught short when they make assumptions that their clients know that they are supposed to sing or play. Verbalization is a good way to clearly Outline Expectations, especially for clients who are new to the concept of music therapy. Fully agreeing to participate as the therapist expects is also most successful when the client has been given a clear definition of the experience.

- Please sing with me.
- I'd like it if you could play this drum.
- Now is a good time to listen.
- Music therapy is a time for everyone to sing along. Even if you don't usually sing, we'd appreciate you joining in as you can.
- There are a lot of instruments here, so you can have your choice of which one you would like to play.
- After we listen to the music, we can talk about your thoughts or how it made you feel.

- Feel free to play or sing or listen. How to respond to the music is your choice.
- Music often allows us to open up to our feelings. Sharing these feelings is important to this group and to your therapy.

Establishing Boundaries

In any relationship, there are explicit and implicit rules for conduct. Establishing Boundaries through verbalization is a technique that might be necessary when clients are not familiar with or are unable to understand the implicit limits within the therapy setting. This is not the same as disciplining or coercing a client. Instead, it uses clear and timely verbal cues to help each member of the therapy (client, clients, auxiliary staff, or therapist) to know the confines and limitations of behavior, actions, or responses.

- Music therapy is a safe space. Everything that you do or say here will be kept confidential unless it poses harm to you or others.
- In this music therapy group, I expect each member to listen and respond respectfully to every other member.
- What happens in music therapy stays in music therapy.
- Please show respect for your partner's boundaries.
- Instruments must be treated with care. You are responsible for keeping them secure.
- I will not allow anyone in the group to feel intimidated or threatened.

For some clients, it is important to use simple, concrete spoken language when Establishing Boundaries. These limitations should be put into place only when it is in the best interest of the client or the client group. Many clients with limited cognition or other processing disabilities come to music therapy because of difficulties in establishing or maintaining personal boundaries. In most of these clinical situations, music interventions work best. However, sometimes simple words or

concise phrases can help move the therapy back into the music as quickly as possible. Some suggestions:

- Please put your hands down on your own body.
- Be safe.
- Be kind.
- It's time to make music.
- We don't do that in this place.
- We don't use those words here.
- No.
- Stop.

One critical component of Establishing Boundaries using Verbal Framing is the concept of one-and-done. As presented here, the sample language is meant to be a quick and economical way to shift the client's actions or responses efficiently back toward the music or other intervention. However, if boundaries or limitations are a critical clinical issue for the client, other techniques or interventions might be a better source of therapeutic exploration.

Giving Directions

Another frequent and effectual use of Verbal Framing is Giving Directions. This technique is similar to Outlining Expectations but includes detailed instructions on how to perform a therapeutic task. This could be something as simple as how to press the buttons on a desk bell or as complicated as how to use recording equipment. As with other techniques in Verbal Framing, accommodations or modifications in vocabulary, syntax, or grammar should be made for individual cognitive and processing differences. The spoken language used should never dictate, but instead guide. It's also often best to limit the use of this technique as much as possible, since in music-making we can use musical cues, gestures, or visual models to Give Directions.

- Please move your chair here next to the instruments.

- Use your index finger to swipe the chimes to make a softer sound.
- The music calls for hitting the drum three times and then stopping.
- First, listen to the entire song. After it is done, we will talk about it.
- In order to have time to reflect on the music, please take two or three minutes to sit in silence after it's over.
- Listen and wait.
- Play now.
- All done.

SUMMARY

Verbal Framing is words and verbalization used by the therapist to direct, guide, or inform the client. The spoken language is simple, clear, and concrete and focuses on the immediate environment and circumstances. The client is not expected to verbally respond. Verbal Framing techniques include Creating the Image; Initiating the Spoken Greeting; Setting the Tone; Defining the Experience; Outlining Expectations; Establishing Boundaries; and Giving Directions. In each of these techniques, words, grammar, and syntax should be adjusted for client differences. Before choosing to use Verbal Framing, the therapist should consider music, visual models, or gestural cues as the primary technique or for use in conjunction with verbalization.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Read or reread music therapy sources that seek to define the practice or the profession. Explore which of these definitions best fits your manner of practice.
- The use of Verbal Framing requires that the music therapist be very grounded in their personal definition of music therapy as well as secure in their ability to

sensitively lead. Reflect or journal on your sense of confidence as a professional or professional-to-be.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Each of the Verbal Framing techniques discussed above gives a list of sample words or phrases to help you increase your basic verbal skills repertoire. For each of the techniques, write out four or five more samples of spoken language that you can use in your practice.
- Explore how Verbal Framing techniques can be used in Wheeler's insight music therapy with reconstructive goals or Bruscia's Primary level. Write out a sample script for each technique.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Imagine that you work in a school for children with developmental delays. Practice using each of the Verbal Framing techniques in both individual and group sessions.
- Imagine that you work in the rehabilitation unit of a hospital. Practice using each of the Verbal Framing techniques in both individual and group sessions.
- Imagine that you work in a nursing home in a unit for people with dementia. Practice using each of the Verbal Framing techniques in both individual and group sessions.
- Imagine that you work in hospice. Practice using each of the Verbal Framing techniques in both individual and group sessions.

Chapter 9

VERBAL EXCHANGES

People exchange things frequently. Gifts at parties. Phone numbers or addresses. Information, glances, or handshakes. An exchange indicates a two-way relationship. You give something, and you get something in return. Verbal Exchange implies a two-way connection. For verbalization in music therapy, this basic technique indicates that the therapist or client will initiate a spoken dialogue and the communication partner will respond. As with exchanging gifts at a party, the dialogue often follows a familiar routine. Giver: "Happy birthday, hope you enjoy this present." Receiver: "It's just what I wanted. Thank you." Giver: "You're welcome." Another example might be a conversation at a restaurant. Server: "What would you like to order?" Customer: "I'd like your special." Server: "With or without an appetizer?" Customer: "Without, thank you."

Both of these examples demonstrate key characteristics of Verbal Exchanges—two-way interchange that tends to follow an expected course. A predictable give-and-take through words. The content centers on the immediate environment, events, or experiences. The purpose of Verbal Exchanges can be to gather and provide information; to give a concrete answer to a concrete question; to respond to a directive; to question a directive; to add more detail to a personal connection; to gain acceptance of a proposal or concurrence with an idea; to agree to simple rules or policies; or to decide on a procedure, protocol, or routine.

All of the uses for Verbal Exchanges listed above might make these techniques seem shallow or superficial for therapy. However, a good deal of the foundation for providing and receiving therapy happens during Verbal Exchanges. Think back to the restaurant scenario from above. In Verbal Framing, the server would state, "For your dinner tonight, I will be

bringing you the special of the day." This might be fine if you really wanted the special, but not so good if you craved another menu item. This kind of restaurant would not stay in business long. In most transactions, either professional or personal, both parties need to find a way to communicate agreement. It is within this reciprocal communication that contracts are made and relationships begun. This is one key purpose for the use of Verbal Exchanges.

The dynamics of social conventions are also played out in Verbal Exchanges. Who will go first? Who will go next? How will we agree to share the space or the time? What details about you do I need to know in order to effectively relate? Under what unspoken rules or controls do you operate? What specific actions will you accept or reject? What do you want or need? These are not idle questions. They are not only considerations of the therapist, but also of concern to the client.

Verbal Exchanges are used in all levels of therapy and all models of music therapy. To be most effective, the techniques of Verbal Exchange should be quickly followed by a move to music, Verbal Interactions or Verbal Interventions. While actions, gestural, or music techniques might meet some of the same aims of Verbal Exchanges, often words and spoken language accomplish the task more quickly.

Entering the Clinical Space

The clinical space is a fluid concept that includes not only physical space (perhaps a room) but also musical, emotional, social, and sensory space. As with a physical room, entering someone else's space comes with the possibility of invasion of privacy, perceived lack of respect, and even concern with personal safety. With Verbal Exchanges, both client and therapist can outline and agree to jointly enter the clinical space. Either the client or therapist could initiate this exchange, but it is mostly the case that the therapist controls the first entrance. This is often due to the real-life details of scheduling and funding. This makes it even more important to the establishment of the

therapeutic relationship that the client have equal opportunity to accept or reject Entering the Clinical Space. Therapist:

- May I come in?
- Is it all right if I join you?
- I'd like to introduce myself. Is it okay if I enter?
- Is now a good time for music therapy?
- I'm from the music therapy department. Can I have a few moments of your time?
- Music therapy is on your schedule now. Would that work for you?
- You are welcome to come in now.
- I'm ready—are you?

These verbal phrases are all focused on the concept of physical space, but the clinical space is so much more than that. The following suggestions reflect the musical, sensory, emotional, or social aspects of clinical space.

- You appear to be tired. Would you prefer that I come back another time?
- I can only imagine that this is a challenging moment for you. Would you like me to stay or go?
- I am happy to see your family here. Did you want them to join our session?
- I see your roommate is here. Can we still have music therapy?
- Are you alright with me bringing my instruments along?
- Your mom told me that you don't like loud sounds. What do you think about the sound of my guitar?

The most important element of Verbal Exchanges is what comes next—the client response. As important as the ability to choose appropriate verbal language is, so is the ability to listen to and fully understand the client's response. This is more complex than it might seem. We've alluded in previous chapters to the idea that spoken words don't always tell the complete and authentic truth. As a music therapist, we can listen to the words a client

speaks with a musician's ear to detect incongruence or partial meaning. An example of this might be working with a young man with Down syndrome. One of the characteristics that some people with this condition display is difficulty in accepting new or novel situations. So, if a new therapist chooses to use words to enter into their clinical space, the initial response from the client might be "No." The therapist would need to quickly decide whether this response were an indication of informed refusal or a symptom of an underlying developmental challenge.

A very different scenario is frequently played out with some older adults. A lifelong practice of formality and manners might lead the client to answer "Yes" to the therapist just to be polite. The therapist might need to be particularly attuned to body posture or attention to determine whether the client was willing to meaningfully engage in the clinical space. In either circumstance, the therapist needs to respond back to the client by adhering to the client's verbal response or by moving to a more intimate verbal dialogue through Verbal Interactions to uncover underlying messages.

Gathering Information

Music therapists know that there is much to uncover about a person through their music. However, critical details required to proceed in therapy can often be learned only through words. These details for the therapist range from the simple (name, contact information) to the more complex (diagnostic history, funding source). The client also needs to gather information from the therapist in a similar manner—name, credentials, education and training, focus of practice, expertise, cost, scheduling, or location. Words generally work well for gathering this type of information. As with Entering the Clinical Space, the manner of exchange itself can also uncover less explicit information about a person, including their ability to relate. This can be shown through body language, tone of voice, or style of language used.

The use of verbalization in Gathering Information requires sensitivity in how and when the exchange takes place in order

to demonstrate respect for the client and their right to privacy and confidentiality. It is often best to begin with an Entering the Clinical Space dialogue. This assures the therapist that they have been given permission by the client to enter into a therapeutic association. To maintain respect and mutuality with the client, Gathering Information should never feel like an invasion of privacy. The therapist should gather only information that they are entitled to by their scope, governmental authority, and facility regulations. It should only include the information they need to effectively provide therapy. It is within the client's right in therapy to share only the information they want to share.

When it is factual details that we need to know to proceed with therapy, simple and respectful questions often work best. Some suggested language:

- Is it okay if I ask you some simple questions to get us started?
- I was able to find out some things about you from your chart. Can I tell you what I discovered to see if it is all correct?
- Can I ask you about your pain level today?

If we are looking for broader information, an open-ended statement can work well:

- Please tell me what you would like me to know about you.
- I think it would be most helpful if you told me some things about yourself.
- I'd like to begin by learning more about you.

Many times, clients in music therapy are unable to provide information themselves. In this case, we can use the same Gathering Information techniques with other professionals, family members, or guardians who have been given permission to answer on behalf of the client. The same principles discussed

above apply whether speaking with clients or with an agent of the client.

Creating the Contract

It is the client who defines therapy. It is the client who determines the course of their therapy. It is the client's right and responsibility to agree to therapy. It is the client who decides whether to enter into a therapeutic contract. This client right is supported in ethical practice, law, and regulation. But the therapist is the one who often draws up the contract, clearly spelling out the benefits, harm, responsibilities, and parameters. In Creating the Contract, the therapist presents the client with an appropriately worded explanation that can be clearly understood by the client at their level of cognitive and linguistic functioning. Although the client's parents or guardians might agree to the contract on the client's behalf, it would still be ethical practice for the therapist to make clear that the therapist has something to offer that the client may or may not agree to accept.

Several steps are involved with this technique of Verbal Exchange. In Creating the Contract, each participant comes with a set of expectations that will need to match in order for the exchange to work. Let's use the restaurant analogy above. Think about the problem encountered if the patron were expecting a gourmet meal but the server was delivering fast food. Or if the server expected a healthy tip and the patron came from a country where tipping was not the norm. It is best practice to make sure that expectations from all parties are clearly stated and agreed upon.

This might seem like a daunting task to accomplish in the often-hectic venues in which music therapists practice. Nevertheless, it is necessary. It might help here to imagine another analogy. You look on the Internet and find a local company that paints houses. You call the phone number and ask if they paint houses in your area. The kindly woman on the phone cheerfully answers yes and asks for your address. You mindlessly rattle if off and then hang up. A week later, the painters arrive, and by the end of the day, your house is the color

of your beet-red face and the painters are waiting with their hands out to take your check. Ouch! In this story, neither participant clearly outlined what was expected, and the result was pretty disastrous. Sound silly? You might want to take a moment to relate this story to music therapy practice. Have you ever assumed that your client understood music therapy only to find out later that their view and yours were far, far apart? Have you begun a session with certain expectations of your client's participation only to be disappointed when they didn't respond?

The more clearly you define music therapy and outline the benefits, responsibilities, and expectations for the therapy, the more constructive the outcome will be for both you and the client. Your client can then make a well-informed decision on whether to enter into the contract, negotiate changes, or decline. The process of Creating the Contract through Verbal Exchanges looks like this:

- The therapist uses spoken language to explain music therapy as it relates to the client. This includes benefits, harm, responsibilities, expectations, and parameters of treatment (length, cost, duration, discharge).
- The therapist then verbally guides the client to affirm, question/modify, or deny the services as described.
- The client uses spoken language, written language, gestures, or actions to accept, amend, or deny services as described.
- The therapist then acknowledges the client's stated wishes and moves to the next therapeutic action.

Here is a possible scenario and sample of a therapist using verbalization to Create the Contract. Mrs. G is in a long-term rehabilitation center. She is often in pain, and this had led to periods of depression. She was referred to music therapy by her physical therapist, with the goal of increasing Mrs. G's motivation for physical activity.

- Therapist: "Good morning, Mrs. G. I am from the music therapy department, and your physical therapist

> suggested I come and meet you. As a music therapist, I know that the right kind of music can give people the boost they need to keep moving and decrease their feeling of the pain. I'd be happy to play some music that you like for the next 20 minutes or so to see if we can find some that will help increase your energy and make your physical therapy less painful. In the beginning, you will just need to listen and join me in playing a few instruments if you would like. Then we can see if you would like me to come back another time. Would you be okay with joining me in some music therapy?"

If you analyze the paragraph above, you will find that the therapist clearly identified themselves, their position in the facility, the referral source, the benefits of music therapy for the client, the expectation of client participation, the right of refusal, the responsibilities of the therapist, and the parameters of treatment. You will notice that the words did not focus on Mrs. G's depression, since the referral source did not mention that as a need. It is possible, if Mrs. G agrees to treatment, that at some point she might bring the issue of depression up either in a Gathering Information context or as a request to modify the contract to include exploring issues of depression. This might happen like this:

- Mrs. G: "I noticed that when we were singing that old Irish jig, I not only didn't feel as much pain, but I felt a little less low, less depressed."
- Therapist: "Yes, music often helps with our mental health as well as physical health. We could either talk more about how you have been feeling emotionally or we could play some more music that you think will help you feel better both physically and emotionally. Which do you think is best at this time?"

In this level of Verbal Exchanges, the therapist would not move toward probing or challenging Mrs. G verbally to discuss her depression until Mrs. G. agrees to add it to the contract. If this

happens, the therapist then would be ethically free to move to Verbal Interventions.

The scenario above involved a client who was able to cognitively and linguistically understand and agree to a verbal contract. Verbally Creating the Contract can also be beneficial with clients who require simpler language and less abstract concepts. A sample is below.

- Rodney came to music therapy group on a Saturday with other housemates from his group home for people with intellectual disabilities. He had been identified by the group home staff as needing to improve his ability to communicate respectfully with his peers.
- Therapist: "Hey, Rodney. Good to see you. Today, all your friends and me are going to play instruments. In music, we're going to start and stop playing all together. When we do this, it sounds like music, and not like noise. I'm going to help everyone by playing my guitar and showing you when to begin and end. You can choose to play with your friends and start and stop with them, or you can sit and listen."
- Rodney: Nods his head and takes an instrument.

An even simpler example of Creating the Contract within Verbal Exchanges:

- Cheryl was in a home-based hospice program. The music therapist had been visiting her for several weeks. Today, Cheryl appeared to be physically much weaker than she was during the last visit.
- Therapist: "I am glad to be with you, Cheryl. I remember from our chat a few weeks ago that you find it helpful to have music in the background as you try to fall asleep. Would it be okay with you if I improvised quietly with my guitar to see if that will help you relax? I'll watch carefully to see if it is working. Would you like me to play?"

- Cheryl: Opens her eyes, looks for a few seconds at the therapist, and then blinks once.

It would be important at this point to be mindful that Verbal Exchange is only one way to Create the Contract. Certain clients, such as young children with significant disabilities, can still agree to a contract through the music-making. If you are providing client-centered and engaging music, the young client will affirm the contract by moving to engage in the music with you.

One final thought about music therapy contracts: Contracts are a two-way relationship. You, as the therapist, are free to create a contract for the client that is specific to your practice orientation or manner of working. However, if this doesn't fit the needs or wishes of the client, they are under no obligation to comply. As discussed earlier in the chapters on Scope of Practice and Levels of Practice, you are ethically obligated to practice within your scope and level. You are also obligated to be very clear with your client what your responsibilities and expectations would be within therapy. If your idea of the music therapy contract and your client's idea do not match, it is best to withdraw from the relationship and help them find another therapist.

Defining Boundaries

Even though a contract has been verbally presented and agreed upon by client and therapist, there are still many areas of contact that need to be worked out. Defining Boundaries is one of these areas. It is a place where there is a verbal give-and-take not only of words but also of ideas, wants, wishes, or limits between the therapist and client. It is almost like negotiating the specific details of the contract. The boundaries can be as simple as "Am I standing too close to you?" or as complex as "Did you want to discuss that issue?"

Defining Boundaries, as part Verbal Exchanges, indicates that this technique is reciprocal. It is different from the Verbal Framing techniques of Establishing Boundaries or Giving

Directions because in those, the therapist engages in one-way communication toward the client.

In Verbal Exchanges, either the client or the therapist can initiate verbal discussion about boundaries. Boundaries can be physical, sensory, motor, musical, social, emotional, or spiritual. Frequently a Verbal Exchange about boundaries can lead either the client or the therapist toward further Verbal Interaction or Verbal Intervention or back into music. An example here might help.

- Jeffrey was in a school-based program for troubled teenagers. He was thriving in the program academically, socially, and musically despite a long history of abuse. In his twice-weekly music therapy group, he played with great musical sensitivity and connection to the others. During the 45-minute session, he seemed relaxed and happy. When the music therapist stopped the music and asked the group how the piece made them feel, Jeffrey spoke up first: "Hey, I was really getting into the music. Can we save this talk stuff for later?" The music therapist smiled, and said, "Sure, we'll get back to it another time."

In this case, the client very clearly set the boundaries of when and where he was willing to engage in Verbal Interventions. The music therapist respected those boundaries, while offering another opportunity.

Another case:

- John's addiction recovery program mandated that he attend music therapy groups. The music therapist clearly laid out the contract, which stated that this group would use music and lyric analysis to explore issues relating to addiction. John verbally agreed to the contract. However, during the session he would often interrupt the discussion by fiddling around with his drumsticks and playing redundant rhythms on the snare. The next time John interrupted, the music

therapist verbally reminded him of the group's focus and expectations and told John that the group expectations did not support his playing during the group discussions. He then asked John if he wanted to respond to the group with a discussion about changing expectations.

In this instance, the music therapist used spoken words to set limits and boundaries for John as well as reiterate the responsibilities of the rest of the participants. This became a Defining Boundaries technique because there was the expectation of a response from both client and therapist.

Some more sample language in Defining Boundaries is below.

- Therapist:
  - I'd like to play the harmony. Do you want to improvise?
  - Let's all decide how fast or slow we are going to play this piece.
  - Please tell me what instrument you think I should play and what you are going to play.
  - This doesn't seem the time or place to share that information. We can make time later for just you and me to talk.
- Client:
  - I don't want to talk about it now. Maybe another time.
  - It makes me uncomfortable to play like that. Is there another song we could do?
  - That's much too loud. Is there a reason the music needs to be that loud?
  - I know you want to explore that issue, but I'm not ready yet. Let's get back to the music.

Deciding on Roles

There are both implicit and explicit expectations within therapy and the therapeutic relationship. Perhaps one of the most

challenging to the new therapist is the decision on roles within the therapeutic experiences. Who is the leader? Who is the follower? Is one person's opinion more important? Who sets the rules and who enforces those rules? Who decides what kind of music to play ... which songs to listen to?

There is an almost natural inclination for the therapist to be placed in a role of authority, both by the client and by the therapist himself. This happens more frequently in some models of music therapy than others but is not always necessary for therapy. When using the Verbal Exchange technique of Deciding on Roles, the emphasis is on a shared decision-making process as to who will assume which role at any given time. Role assignment, role assumption, and role release happen very effectively in music-making and are clear music therapy techniques. Using verbalization in Deciding on Roles can move the process along more quickly or help to make the decisions more precise. Here are some illustrations of spoken language the therapist can use in Deciding on Roles.

- Did you want to set the tempo, or should I?
- Can you tell me how you want to decide what we are going to do today?
- Let's figure out how we are going to get organized.
- Tell me if you want to lead the discussion after we play.
- Are you okay if I ask you some questions about your experience?
- How do you want to continue?
- What do you want me to do now?
- Please tell me if there is something you would like me to change.
- I'd like to discuss that issue more. Are you ready for that?

SUMMARY

In Verbal Exchanges, the therapist and client engage in reciprocal verbalization focused on the simple exchange of information or response to directions or guidance. The focus of

the words and language is on the immediate environment or circumstances. Verbal Exchange techniques include Entering the Clinical Space, Gathering Information, Creating the Contract, Defining Boundaries, and Defining Roles. All of the techniques in this category denote two-way communication between client and therapist and require the therapist to carefully listen to and understand both the implicit and explicit meanings of the client's words before responding.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- This chapter covered several ideas that might seem out of place in music therapy practice. Take some time to reflect on how you perceive the importance—or lack of importance—of the concepts of contracts, boundaries, and roles in music therapy.
- A Verbal Exchange denotes two-way communication. Reflect back on the techniques used in Verbal Framing. Which of these two categories of verbalization covered so far do you most use? Why? Journal about the idea of unilateral as opposed to two-way communication in your work.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Each of the Verbal Exchanges techniques discussed above gives a list of sample words or phrases to help you increase your basic verbal skills repertoire. For each of the techniques, write out four or five more samples of spoken language that you can use in your practice.
- Explore how Verbal Exchanges techniques can be used in each level of practice discussed in chapter 4. Write out a sample script for each technique.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Imagine that you work in a school for children with developmental delays. Practice using each of the Verbal Exchanges techniques in both individual and group sessions.
- Imagine that you work in the rehabilitation unit of a hospital. Practice using each of the Verbal Exchanges techniques in both individual and group sessions.
- Imagine that you work in a nursing home in a unit for people with dementia. Practice using each of the Verbal Exchanges techniques in both individual and group sessions.
- Imagine that you work in hospice. Practice using each of the Verbal Exchanges techniques in both individual and group sessions.

Chapter 10

VERBAL INTERACTIONS

The Verbal Framing and Verbal Exchanges techniques outlined in the previous chapters are not specific to music therapy, or even therapy, and can easily be applied to many other professions that include person-to-person engagement. As we move into the next category of Verbal Interactions, verbalization takes on a more central role with greater therapeutic purpose. The use of words changes from attention on external events to a focus on the "self" and the relationships that contribute to "self."

The term "interaction" is generally accepted to mean a reciprocal action or influence. Verbal Interactions provides the opportunity for both the therapist and the client to engage in meaningful and personal connections. In Verbal Interactions, the explicit as well as implicit contract contains the agreement that each participant will relate in a manner that is personal and meaningful, all for the sake of the client.

It might be helpful at this point to put Verbal Interactions into an everyday context. Dorothy has recently lost her husband of 56 years. As she works to normalize her daily life, she makes herself go to the grocery store where she and her husband would often do their weekly shopping. The staff, from the checkout clerk to the produce manager, stop to give her their condolences and to ask her how she is doing. Dorothy has learned to expect this and politely responds to each person with a wistful but kind reply—"I'm doing as well as possible, and I know that my husband would appreciate your continued kindness to me." This type of Verbal Exchange follows a type of well-meaning but rote formula that addresses Dorothy's external circumstances without moving into a deeper conversation. Contrast this verbal dialogue with the one that Dorothy has next with her music therapist. The therapist knows

not to ask Dorothy how she is doing and opens the conversation with "Would you like to tell me about your day today?" Dorothy responds with an honest appraisal of her sadness and feelings of hopelessness. The therapist then asks whether she would prefer to explore these feelings in the music or to talk about them. While engaging in this dialogue, the therapist is also exploring her own feelings connected to sadness and her empathy for Dorothy. Both therapist and client move away from the external environment to the internal world of feelings and emotions. This is an example of Verbal Interactions.

In Verbal Interactions, the therapist and client engage in reciprocal verbalization with the intent to create or sustain therapeutic relationships; share meaningful information about the music experience; or to communicate social and emotional content related to the music. This is done through providing feedback, reflecting, rephrasing, or translating communication or responses within the session. The words and language focus on conscious material presented by the client in the immediate environment and circumstance. Verbal Interactions can lead back into the music-making to resolve therapeutic issues or move to Verbal Interventions.

Many of the authors cited in the literature review chapter provide guidelines and samples of verbal skills that would fit into the category of Verbal Interactions. In the Levels of Practice framework outlined by Wheeler (1983), this type of verbalization would most often be within insight music therapy with re-educative goals. In Bruscia's levels (2014), Verbal Interactions could be used in both the Augmentative or Intensive levels.

Before beginning to use Verbal Interactions (and later Verbal Interventions), it is critical that the music therapist have a thorough understanding of these levels of therapy. To lay a foundation, let's quickly review key components in two areas of practice that are related to and influence the use of words in music therapy: counseling and psychotherapy. A 2017 article in the *Journal of Music Therapy* studied music therapists who were also qualified to practice counseling. The article identified the following verbal techniques that these dually trained

practitioners used: questioning, feedback, paraphrasing, summarization, reflection of meaning, reflection of feeling, interpretation/reframing, confrontation, self-disclosure, role-playing, encouraging, logical consequences, and psychoeducation (Sevcik, 2017, pp. 300–335).

In 2014, Tschacher and colleagues conducted a study of psychotherapy practices and surveyed experts to develop the following list of common factors in psychotherapy practice: therapeutic alliance, mitigation of social isolation, provision of an explanatory scheme, instillation of hope, readiness to change, patient engagement, resource activation, affective experiencing, affective catharsis, problem confrontation, desensitization, corrective emotional experience, mindfulness, emotion regulation, cognitive restructuring, mentalization, behaviour regulation, mastery experiences, self-efficacy expectation, and new narrative about self (Tschacher, 2014, pp. 82–96).

Perhaps one of the best-known guides for practice in psychotherapy comes from the prolific author Irvin Yalom. His list of therapeutic factors in psychotherapy include: instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors (Yalom, 2005, pp. 1–2).

Each of the sources referenced above gives complete definitions for the therapeutic factors and verbal techniques of psychotherapy and counseling listed. Please note that this short review is not intended to substitute for more intensive study and understanding of best practices in mental health.

Below we will further explore some purposes for using Verbal Interactions and suggest specific supportive verbal techniques.

Creating and Sustaining the Therapeutic Relationship

The therapeutic relationship is at the core of many models of music therapy practice. Creating and sustaining this

relationship in music therapy involves a complex combination of deeply connecting in the music as well as through words. This requires the therapist to have empathy and respect for their clients. The therapeutic alliance is then strengthened through finding connections where therapist and client can discover musical, emotional, social, cognitive, or spiritual contact. These moments of contact often allow for feelings of intimacy during the clinical experiences. Equally as important for our clients is the opportunity for honesty. As therapists, we must also be ready for resistance and can create a chance for this in Verbal Interactions through Validating Negative Projections.

EMPATHY

Empathy is a key quality of the effective music therapist. Fortunately, Dr. Kenneth Bruscia has articulated some techniques for developing empathy, along with guidance for using them in verbalization, in the "Sixty-Four Clinical Techniques Used in Improvisational Music Therapy" presented in his book *Improvisational Models of Music Therapy* (1987):

> ***Imitating***
> Imitating may also be implemented verbally. It involves repeating verbatim what the client says and depending on the purpose, with the same or different tonal inflection. Verbal imitating can be used to reinforce the client's statement, to elicit clarification, or to induce self-awareness. (p. 538)

> ***Pacing***
> In speech, the therapist talks at the same rate and volume as the client. ... Whether pacing in the same or different modality, an important clue for the therapist is the client's phrasing. Often, the client has a characteristic way of shaping (or not shaping) the energy flow in his/her music, speech, or movement. Effective pacing may therefore involve either matching the length and shape of the client's

phrasing, or using the technique called "shaping." (pp. 539–540)

Reflecting
In verbal reflection, the therapist verbalizes about the moods or feelings expressed by the client through words (unimodal), music (crossmodal), or movement (crossmodal). Verbal reflection may accompany or follow the client's self-expression in music or movement but always follows the client's verbal expression. When verbally reflecting the client's verbalizations, the therapist need not use the same words as the client to convey the feelings and meanings expressed through them. (pp. 540–541)

These techniques outlined by Bruscia point the music therapist toward how the words are spoken to create empathy rather than specific words or phrases. The timbre, tempo, and patterns of the speaking voice often convey empathy and caring more clearly than the vocabulary used. However, the words you choose, along with empathetic qualities of your voice, can be a powerful combination in establishing and maintaining a therapeutic relationship. Below are some suggestions.

- Sounds of affirmation, such as "Mm-hmm."
- Yes, I can only imagine how that feels.
- I am here for you.
- Please go on.
- I understand. I get it.

Respect

The idea of respect for the client and their individual circumstances has been woven throughout this book. Words can carry implicit messages of respect or lack thereof. When selecting vocabulary, the music therapist needs to be sensitive to words that might diminish the client's perception of the therapist's attitude of respect toward the client. Regard for the

client's culture, gender, age, ability, or ethnicity should be considered in every Verbal Interaction. Some general guidelines:

- Approach the client as a person. Use person-first language.
- Reference the person's disability only if this is integral to the treatment.
- Address the client in the manner in which they prefer.
- Follow the client's lead in determining how formal or informal your conversations should be.

Finding Connections

In music therapy, music is the unique point of connection for the therapist and client. But Verbal Interactions can be helpful in bringing the music into sessions more quickly. This can be done through conversations on music or on the client's relationship to music. Sometimes, the client is more comfortable Finding Connections with the therapist on topics of interest other than music. The music therapist would then need to connect the topic to the music. Sometimes, the therapist can begin with appropriate self-disclosure. There are an infinite number of possibilities for word use, but some suggested language might help to get you started.

- Tell me what kind of music you listen to at home.
- Who are your favorite musicians?
- It would be very helpful if you would share your playlists with me.
- Tell me a little bit about yourself and the things you like to do.
- I really like country music. How about you?
- I see that you are interested in sports. Can I play some songs about sports for you?
- Did you play an instrument when you were younger?

It is important for Finding Connections to engage in multiple Verbal Exchanges with the client to allow for a full and robust

trade of information. Here is one sample scenario:

- Therapist: "I see you are wearing a t-shirt with a rock band logo on it. Is that band a favorite of yours?"
- Client: "Yeah, I used to listen to their music all the time."
- Therapist: "What did you like most about the music?"
- Client: "The lyrics really got to me. But I mostly liked the rhythm."
- Therapist: "Tell me more about the lyrics and the rhythm."

Intimacy

The therapeutic relationship is frequently very different from any other relationship that a client might have. The challenges that bring a client to therapy often limit the types and depths of relationships they have in other areas of their life. Sometimes, there is an intimacy to the relationship with the therapist that is not available anywhere else for the client. Again, the qualities of Intimacy are generally most effectively conveyed through timbre, tempo, dynamics, and the pacing of your voice rather than the words used.

There is sometimes a concern with Intimacy that use of certain words or phrases can cross a boundary of professionalism. This is where words might counteract the deep intimacy within the music. Phrases such as "I love you" or "You are the best" when used by the client can support the therapeutic relationship but are most likely not helpful when coming from the therapist. This is a situation where validation of the client's intent might be the most effective response. Some language that validates the client's feelings of intimacy without crossing professional boundaries is suggested below.

- I can hear from your music and your words that this experience is very meaningful for you.
- Thank you for putting so much of yourself into the music.
- It is great to be able to experience this moment together.

VALIDATING NEGATIVE PROJECTIONS

So far, the verbal skills discussed have focused on words that are positive and support a constructive and collaborative therapeutic relationship. But, as every therapist knows, clients sometimes project negative emotions on or toward the therapist. These negative projections can be played out in the music but can also come from the spoken language that the client uses. The underlying issues are often directly connected to the client's challenges. The therapist must then make a clinical decision to explore the issues musically or move toward exploring them through verbal discussion. However, there are a number of reasons for the therapist to bring the focus back toward the music. These include acting in the best interest of the client or because the therapist is unprepared for Verbal Intervention work. As seen above, validation of the client's intent through use of Verbal Interaction, when carefully used, can be helpful in moving the therapy back into the music.

- I sense from your words that you are quite angry. Can we play this out in the music?
- Please put your emotions into action through the music. This way, we can work together to see what is happening.
- Sometimes, words don't tell the whole truth. I'd like to see if we can work out these feelings in the music first.

Words can also be used to move the process toward more in-depth Verbal Interactions or Verbal Interventions.

- Those are some very strong feelings. I'd like to see if I am understanding what you are trying to tell me.
- Can you explain that to me in another way?
- Let's take a moment talk about how you are feeling.

Sharing Meaningful Information About the Music Experience

Verbal Interactions provide an efficient way for the client and therapist to further quantify the music experience through spoken language. Although there is an almost universal belief among music therapists that the music experience itself has meaning for both client and therapist, there is often an urgent compulsion to validate the musical meaning through words. To paraphrase Wigram et al. (2002) as quoted in chapter 1, words have an exactness in representing the internal and external worlds that music lacks. This urge to use words to complete the music experience can be frequently seen in the therapist quickly guiding the client toward discussion or in the therapist's impulsive comments such as "That was great" as a young client finishes a rousing rendition of a song. It would be important for the music therapist to reflect on whether spoken comments after the music ends is a purposeful technique or the result of a habit of using words to fill in auditory space. Leaving space at the end of a music experience, just as leaving space within the music, provides the client with the opportunity to choose how to respond to the music. This response could be through facial affect, body posture, a return to musical action, or the use of words and Verbal Interactions.

If it is determined that the most appropriate technique is to guide the client into using words to share meaningful information on the music experience, the therapist can lead the discussion toward a variety of related categories: specific musical details, details on the act of music-making, physical sensations connected to the music experience, the perceived social aspects of the music experience, the feelings that arose in response to the music experience, or spiritual or transpersonal connections to the music-making. Some sample phrases or sentences to help in guiding the discussion are below. As in prior suggestions, there are both direct questions as well as open-ended statements designed to encourage further Verbal Interaction.

Specific musical details:

- The structure of that experience seemed quite unique. Let's talk about how it was constructed and how that felt to you.
- What did you think of all those rhythm and tempo changes?
- We used a lot of instruments in that piece. I'd like to explore how you made the choice of which to use.
- I really liked the melody of that song. What about you?

The act of music-making:

- How come you chose to play the piano rather than the drum set?
- That's a complex instrument to navigate, but you played very freely. I'd like to know how you did that.
- The tempo you chose was really fast. That could be fun or tiring. Which was it for you?
- I noticed that you have great breath control when you sing. That can be challenging.

Physical sensations:

- That kind of experience can be really draining. I'm a bit spent from it.
- Did that music give you any more energy?
- Wow. It's amazing what music can do to the body.
- Did you sense a change in how your body feels after we played?

Perceived social aspects:

- Tell me how you think we all sounded together.
- Could you hear everyone's part as they played?
- I'm looking around the room and wondering if anyone had the same responses to the music that I had.
- How do you think your playing fit into the whole music experience?

Feelings or emotions that arise in response to the music experience:

- Did that song bring up any feelings for you?
- Often this kind of music makes people feel strong emotions. I'm curious if it was the same for you.
- Wow, that was powerful.
- Do you want to explain what feelings you are experiencing right now?

Spiritual or transpersonal connections:

- That experience seemed so much bigger than just the two of us.
- Can you describe the atmosphere that we created with this music experience?
- Music often brings us outside ourselves and our immediate world. I wonder if anyone felt that this time.
- Did anyone feel a sense of larger connections while we played?

As with fostering therapeutic relationships, Bruscia's "Sixty-Four Clinical Techniques Used in Improvisational Music Therapy" also suggest two specific techniques designed to move the focus toward spoken language to share information on the music experience.

In Procedural Techniques: Reporting

- After an improvisation or playback, having the client report on his/her experience while improvising (Bruscia, 1987, p. 536).

In Redirection Techniques: Reacting

- After an improvisation or playback, asking the client what s/he liked or disliked about it (p. 535).

Sharing meaningful information about the music experience not only serves to inform and give therapeutic direction for the therapist, but also gives the client a way to verbally express feelings, thoughts, and ideas within the

generally safe and narrow constraints of a discussion limited to specific topics of the music. In other words, for many people, it is easier to talk about something (the music) than it is to talk about the self (deeper emotions, thoughts, and reactions elicited by the music). This then presents the therapist with the clinical decision of whether to move back into the music or to further explore through verbalization.

Communicating Social and Emotional Content Related to the Music

One of the prime purposes of using music as a therapeutic modality is because music, in and of itself, has emotional and social meaning for most people. Many music therapy interventions are designed precisely as a way for the client to experience and communicate this social and emotional content. As music therapists, we know that music allows for deep exploration beyond words. However, either the client or the therapist might decide to enhance or enrich the therapeutic opportunity for emotional or social expression through Verbal Interactions. Using verbalization for this purpose gives the client a chance to discover and articulate thoughts and feelings toward themselves and others that evolved from the music experience.

A short vignette might be helpful here. Sadie came to music therapy group each Thursday morning in the day room of her assisted living facility. On one particular morning, she spilled her coffee all over her lap because her hands were shaking so much. She got very angry at the young girl who rushed to her aid, telling her that she was perfectly capable of cleaning it up herself. Her dress was still damp when she wheeled herself into group. The music therapist would often begin each session with a familiar song that was a favorite of the group. Sadie felt flushed and agitated as he sang "Take Me Out to the Ballgame." The song grated on her ears as she experienced a memory of singing that exact same song as a youngster. Her anger grew as she thought about how helpless she felt and how she hated the feeling of being treated as a child. When the therapist asked, "Did that song bring up any feelings for you?," Sadie let loose

with a string of angry criticism about the way the group sang. The therapist quickly moved to help translate this unexpected response and suggested to Sadie that sometimes music can bring up unpleasant emotions. Hearing certain songs might be a trigger for an emotional response that is not connected to the music. The therapist asked Sadie if she would be willing to talk a little more about why she was so angry and assured her that he and the group were ready to listen.

Verbal Interactions, as a technique to encourage the communication of social and emotional content, require the music therapist to effectively employ a number of basic verbal skills. These include the ability to use words and spoken language to provide feedback, reflect, rephrase, or translate communication or responses brought up through the music. These verbal skills are directly taken from the American Music Therapy Association's professional competencies.

In this type of Verbal Interaction, the music is still the primary agent of change. It is within the musicing that the person opens up to perhaps a new way of feeling and thinking about self and about self with others. The focus of the discussion remains on immediate and present understandings within the music experience. However, the interactive topics revolve around emotions and social relationships rather than the music experience itself. Depending on the depth of the discussion, the therapist can choose to return to the music or move to Verbal Interventions. Some sample language is provided below; however, it is important for the music therapist to have a solid understanding of psychotherapy and a healthy respect for working within their level and scope of practice as well as honoring the therapeutic contract agreed upon by the client. Note that all of these skills can be used in both Verbal Interactions and Verbal Interventions, but with a different focus and level of therapy.

Feedback

A 2005 article by Claiborn and Goodyear in the *Journal of Clinical Psychology* helped to define the use of Feedback in

psychotherapy. "Though its pervasiveness in human behavior is noted, feedback in clinical practice is a deliberate psychological intervention that has two essential functions, information and influence. Feedback can be descriptive, evaluative, emotional, and interpretive" (2005, p. 209).

When using verbal skills to help a client communicate emotional and social content, the music therapist uses Feedback to give their client information or to provide an interpretation about the content of their words in order to influence changes in behavior or response. Bruscia also refers to Feedback as a discussion technique, describing it as "verbalizing how the client might appear, sound, or feel to another person" (1987, p. 587). Feedback most often deals with overt meaning or actions.

In the case of Sadie above, Feedback might sound something like this.

- Therapist: "I'm hearing that your tone of voice suggests you are very angry. The others also sense that you are feeling mad. We would like to give you a chance to tell us about it, but it is hard to understand what the issue is when you are so upset."
- Sadie: "Yes, I am feeling really angry right now."
- Therapist: "It is good that you can express that. I think your friends were concerned that you were angry with them, but it seems as if there is something else going on. Can you tell us more?"

Notice that in this example, the focus is on the current environment and the immediate situation. The therapist uses Feedback to guide Sadie into a more productive and socially sensitive dialogue.

Reflection

Bruscia includes Reflection within the techniques of empathy. He describes it as "matching the moods, attitudes, and feelings exhibited by the client" (1987, p. 535). Using Reflection to support social and emotional communication increases the

opportunity for the client to feel heard and understood. Within this empathetic relationship, the therapist presents a nonjudgmental and open attitude toward the client. The client, then, is encouraged to openly share. As presented earlier, Reflection is often conveyed through the tone, timbre, pacing, and phrasing patterns of the therapist's voice. When using it for communicating emotional and social content, Reflection can also include words and phrases that match the client's offerings. This necessitates that the therapist listen very carefully to both the client's words and the client's communicative intent. Reflection of the words needs to be very precise, while showing empathy and therapeutic rapport. This also requires the ability to demonstrate neutrality, sending a message of understanding while not having to fully commit to supporting unhealthy ideas, behaviors, or actions.

This incorporation of empathy along with neutrality within Reflection calls for a deep level of self-awareness and introspection from the therapist. In order to truly reflect the thoughts and emotions of another person, the therapist must be completely open and unencumbered by issues of countertransference or self-absorption. For many therapists, this is best accomplished through professional supervision or their own experience in therapy.

Since our client's emotional and social lives are most often complex, the verbal skills needed when using the technique of Reflection must be responsive to that complexity. This means the music therapist must be flexible and creative in their thinking and in their use of verbalization, just as they are within their music-making. Some of the guidelines mentioned previously hold true in this type of Verbal Interaction: awareness of cognitive and linguistic levels; careful listening; and sensitivity to cultural, social, and gender identity. Some suggested language is listed below.

- It seems as if the music has taken you to a very dark place. I imagine that this is a really hard thing to experience.

- When you explained your thoughts about the music-making, I had a sense that you were going through something really difficult.
- Your smile and words make it sound like the music brought you joy. When you say that you are happy and carefree, I can see it in the way you walk and how you talk.
- Yes, sadness sometimes is made more intense by the music. I can see from your tears that you are feeling this very deeply.

REPHRASING

Therapists play a significant role in helping clients to more clearly articulate their thoughts and feelings. This can be done through the music as well as with verbalization. Rephrasing as a verbal technique requires the music therapist to have an open and flexible listening stance. The music therapist then takes both the meaning of the client's words as well as the implied communicative intent and puts these into a summary statement that allows for greater clarity and focus. Rephrasing that truly captures the essence of the client's communication is a skill that might take a good deal of practice for the beginning therapist to master. A general rule of thumb is to focus more on the client's communicative intent rather than the details of the words or phrases. Rephrasing is a particularly important technique when working with clients who have difficulty with the organization of thoughts or who have limited language abilities. Intense emotions also tend to affect the capacity to clearly state ideas.

To illustrate: Imagine a clinical session with a teenage client with developmental disabilities. Gerard wants to talk about his parents and his perception that they won't let him use his computer to play his favorite music. He transitions into a long story about his gaming on the computer and how he always loses when he plays with his brother. The story then moves toward how his brother gets to drive a car and he doesn't. Several themes might be at play in Gerard's story. The therapist might choose to focus on how, in each part, Gerard expresses

frustration at his lack of control over his life. The following Verbal Interaction could follow this path:

- Therapist: "Wow. I am hearing you say that you get frustrated when you don't get to make your own decisions. Does that sound about right?"
- Gerard: "Yeah, they never let me do what I want."
- Therapist: "So, you wish your parents would let you make more of your own choices."
- Gerard: "Yeah."
- Therapist: "Can you think of one choice that your parents would be okay with?"
- Gerard: "How about letting me play music on my computer when I get home from school?"
- Therapist: "Maybe you could sit down and talk to your parents about having more responsibility. Meanwhile, why don't you choose what we should do next in the music. Would you like to be the leader now?"

Some general statements that might be a template for and introduction to Rephrasing are below.

- If I heard you right, I think you were trying to say ...
- Let me see if I get this right. You were telling us ...
- I want to make sure I understand. Please tell me if I'm hearing you correctly ...
- Maybe it would be easier for us to know what you mean if I put it differently. Let me know if this is how you are thinking ...

Translating Communication or Responses

This Verbal Interaction is similar to Rephrasing but also includes using words to give meaning to client responses. This then opens up the opportunity for the client to discuss how their musical behavior or response might be interpreted by others. It is different from Feedback in that it moves the client toward

examining and creating their own way to make changes, rather than having the therapist suggest specific ideas.

Interpreting or translating musical responses into a more generalized statement of the client requires that the music therapist be accurate in understanding the client's strengths and challenges. For instance, if the therapist uses words to sum up a client's loud and unorganized play, the manner of playing must be viewed in the context of the client's overall physical, cognitive, emotional, social, or communicative capabilities. The words used to describe this type of musical response after the client has recently had a massive stroke might be very different from those used if the client has severe mental illness.

Some sample language to help the therapist move Translating Communication or Responses is listed here:

- It seemed as if your music matched the group's music perfectly. Did you feel this way?
- In the music, I heard a bunch of different ideas. It would be interesting to know how that felt to you, but to me it seemed as if we weren't listening to each other.
- Wow, the drums were really loud in that last song. This can make it hard for others to hear their own part. Can you talk about how it seemed to you?
- It looked as if you didn't want to play today. Do you want to tell us about that?

Bruscia identifies a redirection technique called Analogizing that can also be used to help to translate or interpret. He describes Analogizing as "after an improvisation or playback, asking the client to cite a situation in the life that is analogous to the improvisation or experience" (Bruscia, 1987, p. 535). Analogizing might sound like this:

- Therapist: "That was some pretty intense music-making. I'm wondering if there is any place else in your life where you feel the same way you felt when you were just playing with me."

The therapist might also use a Reflection technique to introduce the Verbal Interaction.

- Therapist: "I had a hard time hearing you play today. It seemed as if you wanted to play quietly or maybe not play at all. Does this happen at other times? Were you more comfortable with not speaking? I'm wondering if you could describe how that feels for you."

SUMMARY

In Verbal Interactions, the therapist and client engage in reciprocal verbalization with the intent to create or sustain therapeutic relationships; share meaningful information about the music experience; or to communicate social and emotional content related to the music. This is done through providing feedback, reflecting, rephrasing, or translating communication or responses within the session. The words and language focus on conscious material presented by the client in the immediate environment and circumstance. Verbal Interactions can lead back into the music-making to resolve therapeutic issues or move to Verbal Interventions. In Verbal Interactions, verbalization takes on a more central role with greater therapeutic purpose. The use of words changes from attention on external events to a focus on the "self" and the relationships that contribute to "self."

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Verbal Interactions require the music therapist to move toward a greater responsibility for how words are used in and as therapy. Take the time to read or reread literature on psychotherapy, such as the works of Yalom. Reflect on how you incorporate these ideas into your practice.

- Examine your current music therapy practice and journal on how you make decisions on when to introduce words into the session. Reflect on how comfortable you are with words or with silence.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Each of the Verbal Interactions techniques discussed above gives a list of sample words or phrases to help you increase your basic verbal skills repertoire. For each of the techniques, write out four or five more samples of spoken language that you can use in your practice.
- Explore how Verbal Interactions techniques are used in both the scope and the levels of music therapy practice. For each of the samples above, write out suggestions of language modifications to account for differing cognitive or linguistic abilities.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Imagine that you work in a school for children with developmental delays. Practice using each of the Verbal Interactions techniques in both individual and group sessions.
- Imagine that you work in the rehabilitation unit of a hospital. Practice using each of the Verbal Interactions techniques in both individual and group sessions.
- Imagine that you work in a nursing home in a unit for people with dementia. Practice using each of the Verbal Interactions techniques in both individual and group sessions.
- Imagine that you work in hospice. Practice using each of the Verbal Interactions techniques in both individual and group sessions.

Chapter 11

VERBAL INTERVENTIONS

All of the "talk" within music therapy discussed in the previous levels of verbalization is generally designed to support music as the primary therapeutic intervention. For some clients, though, words, and the cognitive implications of understanding "self" through words, provide the best opportunity for therapeutic change. This is when the music therapist might move to Verbal Interventions if their education, training, experience, and occupational role support its use as an intervention.

The word "intervention" in music therapy literature has itself engendered some controversy as well as confusion. Bruscia removed the word entirely in his updated 2014 edition of *Defining Music Therapy*. In speaking about his decision to exclude "intervention," he explains ...

> ... I was left with the two main concerns about the use of intervention. First, the term carries many unintended but undesirable connotations of power, hierarchy, and client passivity. Second, although it is appropriate to some areas of practice, it is not appropriate for others. Thus, using the term would be exclusionary. (Bruscia, 2014, p. 281)

A review of the literature on verbal skills in music therapy practice reveals a confusing array of descriptive language used to define the use of words as an intervention. The terms "verbal processing," "verbal intervention," "verbal dialogue," and "verbal discussion" were often used interchangeably. This lack of specificity might be one factor in the challenges that students, supervisors, and faculty have reported in teaching verbal skills

to music therapy students (Gooding, 2017). It is also one of the reasons that the term "verbal processing" has not been generally used in this book. As defined by Nolan in his seminal 2005 article "Verbal Processing Within the Music Therapy Relationship," "'verbal processing' ... relates to the talking that facilitates the therapeutic process during, and in response to, music-making or music listening." He further explains that "[f]irst, verbal processing provides the opportunity to increase awareness or understanding about internal (thoughts, observations, and feelings) and external events (within the music and interpersonal areas of experience)" and "[a] second suggested purpose of verbal processing is that it can provide the therapist with a way to gather additional information" (Nolan, 2005, p. 18). This broad definition can easily encompass the more music-activated techniques of Verbal Framing, Verbal Exchanges, and Verbal Interactions as outlined in this volume. A student or young professional might then use the term "verbal processing" to describe any of the spoken dialogue within sessions. This has the potential to trigger concerns about working outside of scope or level of practice if another professional has a different understanding of the term "verbal processing"—one that aligns more closely with counseling or psychotherapy.

Here is a possible scenario. A music therapist attends a team meeting on a client within a mental health facility. The music therapist has the training and experience to work within the Activity level as defined by Wheeler or the Augmentative level as outlined by Bruscia. In the sessions, the music therapist often engages in verbalization with the client, asking them how they are feeling that day, discussing current events in the unit, or reviewing plans for music-making. During the meeting, the music therapist reports that the client engaged in verbal processing as well as music interventions. Another mental health professional on the team treats the same client, using specific verbalization techniques to help the client gain insight. They engage in verbal dialogue to examine the client's unconscious issues. This therapist also reports that the client engaged in verbal processing. Even though the music therapist

and the other mental health professional used the same term, a side-by-side comparison would reveal very different purposes for the uses of words and spoken language in therapy.

To create greater clarity for the music therapist in understanding verbal skills, the term "Verbal Interventions" will be used here to describe the action in therapy when words and spoken language are used as the primary agent of change by both the therapist and client. The verbalization is designed to process, uncover, explore, and confront therapeutic issues leading to client insight. Verbal Interventions include the discussion of immediate experiences as well as conscious and unconscious material brought into the session by either the client or the therapist.

Three clear requirements should be respected before any music therapist employs the techniques of Verbal Interventions: advanced education and training, client consent, and adherence to ethical practice. Before moving to the specific techniques of Verbal Interventions, let's examine each of these requirements in greater detail.

Advanced Education and Training

The words used in Verbal Interventions are the outer symbols indicating a deep understanding of the human condition. The therapist using Verbal Interventions is required to have a knowledge of and respect for the complex thoughts, feelings, emotions, and responses of the client on both the conscious and the unconscious level. They have the experience necessary to respond reflexively to spoken language in the moment and the confidence to follow the client into areas of verbal examination that might be difficult or uncomfortable. The therapist has also engaged in self-reflection in order to uncover their own issues that might interfere with their ability to work fully with the client in verbal dialogue. Some of the advanced models of music therapy practice that would fulfill these requirements might be Analytical Music Therapy, the Bonny Method of Guided Imagery in Music, or vocal psychotherapy. A

more complete discussion of the relationship of verbalization to models of music therapy practice can be found in the third edition of Bruscia's *Defining Music Therapy*.

Client Consent

The use of Verbal Interventions means that there is a clear shift of the primary agent of change in the therapy from music to words. In order to make this change, the therapist must ensure that the client has a full and intact capacity to understand and use words and spoken language. As discussed earlier in the book, this most often also means robust cognitive functioning. In addition, the client must agree to the use of Verbal Interventions as a prime therapeutic avenue. (See the section on Creating the Contract in the chapter on Verbal Exchanges.)

Ethical Practice

Even with client consent and advanced education and training, the ethical music therapist must still respect and adhere to the regulatory parameters of their funding facility and governmental oversight agencies when engaging in Verbal Interventions. If there is a significant difference between the client's needs and expectations, therapist focus, and the roles and boundaries imposed by agencies or regulations, the therapist must work to resolve the issues or adjust their manner of practice.

VERBAL INTERVENTION TECHNIQUES

Techniques that fit into the category of Verbal Interventions have been discussed and explained in many of the formative works on verbal skills in music therapy and briefly mentioned in the literature review chapter. Readers who will continue to learn or use Verbal Interventions beyond the basic skills level should thoroughly study this original material. A particularly helpful guide is the chapter on Verbal Processing in Gardstrom's

Music Therapy Improvisation for Groups: Essential Leadership Competencies (2007).

Some of the techniques discussed in these writings include probing, amplifying, deepening, projecting, role-play, problem-solving, describing, analyzing, reality-testing, free association, focusing, confronting, counseling, connecting, disclosing, clarifying, summarizing, interpreting, acknowledging, influencing, advice-giving, and checking out.

For the purposes of this book, only a select list of Verbal Interventions techniques will be examined: Connecting, Probing, Clarifying, Interpreting, Disclosing, Confronting, and Summarizing. These techniques are ones that might be competently learned and employed by a student or young professional with the support of a basic education and training in mental health. They are also on the list of discussion techniques proposed by Bruscia in his "Sixty-Four Clinical Techniques Used in Improvisational Music Therapy" (1987).

CONNECTING

Bruscia defines Connecting as "verbalizing or asking the client how various aspects of the client's experience or expressions relate to another" (1987, p. 536) He further suggests that Connecting can help a client gain insight or awareness through pointing out connections between actions, responses, events, thoughts, or feelings that the client might not have realized before. Bruscia suggests that Connecting serves to help the client clarify and the therapist interpret. He further surmises that this Verbal Intervention "... is also a very subtle way of confronting the client. By relating aspects of the client's experience that have never been related before, the therapist leads the client to his/her own awareness and insight" (Bruscia, 1987, p. 556).

One way to think about the Connecting technique is to imagine a scene from your own life when something somebody said led you to an "A-ha!" or "Eureka!" moment. Think about a time when you were experiencing job-related stress. At the same time, you find that your right shoulder aches, making it hard to play the guitar. You assume that you have some kind of injury,

but tests show no physical damage. It is not until you drive a coworker home that she puts it all together for you. She notices that you grip the steering wheel hard and tense your shoulders significantly throughout the hourlong drive through traffic. "Wow!" she says. "This job must really be getting you to. Your body is so tense; you've got to ache by the time you get home." A-ha! It often takes an objective observer (such as a friend or therapist) to put together, or connect, different pieces of information and come up with a statement that shows how all of the parts are related to a new and not previously recognized whole. Hence the "A-ha!"

In order to use the Connecting technique effectively, the therapist must have a solid knowledge of how humans work: musically, physically, sensorially, cognitively, emotionally, socially, and spiritually. Connecting also generally means that the therapist is able to organize all of these facets of human experience into a schema that will help to reinforce the understanding of the link between aspects of experience. This schema could be based within music therapy theory or other psychological or developmental theories. Relating differing events in the client's experience would be grounded in the theoretical foundation in which they practice. For instance, an analytical music therapist might interpret connections very differently from a person practicing from a cognitive behavioral therapy basis.

Samples below of Connecting as a Verbal Intervention are given only as a language template and examples and are predicated on the belief that each music therapist has had the education and training necessary to interpret and infer the Connections that are in the best interest of the client.

- I have noticed that each week when you come to music therapy, you begin each session by talking about how sad you are. But your music is always light and bouncy in a major key. Let's talk about which is the best expression of your true feelings.
- Did you hear how sharp and tense your voice sounded when you were speaking about your family? Your music

also seems more edgy after you talk about them. I am wondering if you see a connection between your feelings toward them and your responses here or in other parts of your life.

- You've had a lot of challenges with your health lately. Your feelings of depression that brought you to music therapy seem to have started around the same time. Sometimes, there are direct connections between physical and mental health. Have you detected a pattern between them?
- I've observed that you often interrupt during our conversations. You've also told me that your roommates tell you that you are not a nice guy. Can we talk a little more about this?

PROBING

Probing appears to be a well-used technique as reported in many of the articles about verbal work in music therapy. Bruscia describes probing as "... asking questions or making statements to elicit information from the client" (1987, p. 536). He goes on to say that the technique of Probing has the potential to feel invasive. "The client should feel comfortable enough to reveal him/herself without much prodding" (p. 556). Gardstrom (2007) guides the therapist to always use "open-ended" probes, whether phrased as a question or statement, which are designed to stimulate further verbalization (p. 136).

With the Verbal Intervention of Probing, the information sought by the music therapist should be directly related to the issues brought to therapy by the client. As mentioned before, the client retains the right to share information when and how they wish. Effective use of Probing, then, is dependent on a strong and respectful therapeutic relationship in which the client knows that the therapist is probing for the sake of the client's therapeutic progress. As with any solid relationship, there might be times when Probing makes a client uncomfortable. However, if the therapeutic rapport is strong,

the client will most probably work through the uncomfortable feelings for the sake of growth.

Probing can also be uncomfortable for the therapist, preventing them from using probes to help the client in revealing pertinent information. This could happen for a number of reasons, not least of which is an issue with countertransference. For this reason, many programs that train students to practice Verbal Interventions encourage students to be in their own therapy. For example, the music experiences might bring up past memories of abuse for a client. If the therapist also has unresolved issues around abuse, they might hurry the client back into the music experience rather than probing for greater information about the abuse that could lead to greater opportunity for insight.

The clinical situations in which Probing can be used are varied and complex. Here are several language templates that can help formulate your questions or statements.

- Please tell me about that.
- I'd like to know how you are feeling.
- I'd like to know what you are thinking.
- It would be helpful if you could describe that to me.
- Explaining will let us work on the issue more deeply.
- If you can tell me your feelings toward that, it might give us a chance for greater insight into why.
- How does that make you feel?
- How does that feel?
- What were you thinking?
- What can you tell me about that?
- Can you describe what you were trying to express at that moment?
- Why do you think that happened?
- Could you illustrate that a little more clearly?

Many times, Probing is used to start the Verbal Intervention. But, as mentioned above, the music therapist should have already established a trusting working relationship with the client. As with all verbal techniques, the true value of Probing

is revealed only through the client's response to the probe. Listening openly and knowledgeably to the words as well as the communicative intent of the words is critical if the responses to the probe are going to have therapeutic value. After listening deeply, the music therapist might then move to other Verbal Interventions to Connect, Clarify, Interpret, or Summarize the information gained through Probing.

CLARIFYING

The Verbal Intervention technique of Clarifying is designed to get "... the client to elaborate on, clarify, or verify information that has already been offered" (Bruscia, 1987, p. 536). This is done through questions as well as statements. Bruscia warns that this technique should be used sparingly and should not interrupt the client or take the place of the client's process of clarifying their own statements.

When Clarifying, the music therapist should be careful to focus on the client's words and the communicative intent of the words. This is what makes Clarifying different from the technique of Interpreting. Clarifying questions or statements give the opportunity for both the client and the therapist to arrive at a more complete and accurate picture of the therapeutic issues.

- Please tell me more about that.
- It would be helpful if you could describe that in greater detail.
- Explaining that more will let us work on the issue more deeply.
- What else can you tell me about that?
- Is there anything else you want to tell me about that?
- I think I heard you say ...
- You seemed to be saying ...
- From what I could understand, you ....
- Tell me if I'm getting this right.
- Is that correct?
- Is that what you said?
- Is that what you are trying to say?

- Here is what I heard you say. Please let me know if I'm getting it right.
- Is there another way that you can say that?
- This is how I heard it. Does that sound about right?
- Stop me if I get it wrong.
- Did I hear everything correctly?
- Is my reporting accurate?

INTERPRETING

As Bruscia explains Interpreting, "[t]he therapist offers possible explanations or meanings for the client's experiences. This technique is used to give the client insight about him/herself, to model self-analysis, and to train the client how to make his/her own interpretations" (1987, p. 556). Interpreting is meant to tell the client "why" they think, feel, respond, and behave as they do. The music therapist who uses Interpreting as a Verbal Intervention bears a good deal of responsibility for ethical, informed practice since they are incorporating their own understandings as a basis for judgment. Interpreting generally places the client's issues within a larger context of psychological or developmental theory. Therefore, the therapist should be clear early in the relationship about their own practice foundations so there is no disconnect between the interpretations of the therapist and the beliefs of the client. This can be accomplished in the Verbal Exchange technique of Creating the Contract.

The Interpreting technique compels the music therapist to speak with honesty, clarity, and empathy without resorting to jargon or profession-specific terminology. It is equally important for the therapist to know at which point in the client's therapeutic process the Interpreting technique will be most beneficial. While clients might come to therapy to gain the insights that Interpreting can bring about, the reality of hearing difficult truths about "self" can be challenging in the moment.

The complexities of the issues that are addressed in the Interpreting technique make it difficult to provide specific

suggested language. Below are some phrases that might be useful to get you started.

- In our time together, I've heard a number of your responses that suggest ...
- All of your feelings that we have discussed here lead me to think that ...
- Sometimes, the symptoms that we have talked about in therapy indicate ...
- Have you thought about ...
- Maybe the reason that this keeps happening is ...
- What do you think is the reason for your feeling this way?
- Why is it that you respond this way?
- How do you think other people would explain your issues?

DISCLOSING

In Disclosing, the therapist is "... revealing something personal to the client" or "... talking about oneself during a session" (Bruscia, 1987, p. 537). This technique is meant to assist the therapeutic process and should be used only for the benefit of the client. The Disclosing statement should be designed to encourage the client to verbalize more or to Clarify their comments. Care should be taken to make sure that the therapist's personal details are disclosed only in order to move the therapeutic process forward. Reflection or supervision can be helpful in determining whether the content disclosed is appropriate.

- When I was in your situation a while back, I had the same response as you.
- I sometimes feel the same way.
- I can imagine that, since I have been there before in my life.
- I'd like to tell you a little bit of my story. I think it might be helpful.

CONFRONTING

The technique of Confronting depicts "... challenging the client by pointing out discrepancies or contradictions in his/her responses" (Bruscia, 1987, p. 537) in order to bring insight or motivate change. In moving to Confronting, the music therapist needs to be sensitive to the client's ability and willingness to engage fully in personal introspection and reflection. The therapeutic relationship must be strong, and the client must fundamentally trust that the therapist is acting in their best interest. In addition, it is important for the therapist to choose which client responses are best handled through the Confronting technique. As an example, if a therapist is constantly confronting a client about specific details of a story, the technique might have diminished impact when a Confronting statement gets to the heart of the therapeutic issue. For instance, think about working with a client with anger management issues that ended in incarceration after a road rage incident. A statement from the therapist such as "No, I am sure that the 4th was a Thursday" might not be as therapeutically valuable as "Your thinking about the situation is not accurate. I'd like to explore with you how other people have reported your difficult interactions."

Confronting has the potential for the therapist's own issues to cause either underuse or misuse of the technique. Challenges with engaging in confrontation can be a reason for a therapist to move away from the Confronting technique. This might look like a therapist-directed quick move back to "safe" music or through letting the client's erroneous statements go unchecked. On the other extreme, countertransference could lead a therapist to confront a client when there are not clinical indications that doing so would help therapeutically. Reflection, therapy, or supervision can all help the therapist to be alert to these concerns.

The words and phrasing of Confronting statements should maintain a balance between directness and focus on one side and respect and empathy on the other. This can be hard to do. Often the musical qualities of the words can make the statements easier for the client to truly hear and engage with.

Delivering the words with a calm, measured tone of voice generally works well. Focus on language that doesn't sound accusatory. Generally, beginning with "I" rather than "You" can be helpful. Some suggestions for initiating Confronting statements are below.

- This might be hard to hear, but I need to tell you that ...
- I'd like to present a different perspective.
- Please listen. There are some problems with the way you are thinking.
- That is not accurate. Let me explain.
- I know this is your belief but ...
- How would the other person feel about this? It seems as if there is a big difference between your feelings and theirs.
- How would the other person think about this? I'd like to give you that point of view.
- There is a better way to think about this.
- I need to contradict you at this point. Here is the way I hear it.
- Wait while I describe it a different way.

SUMMARIZING

In Summarizing, the therapist verbally recapitulates the events in therapy and states them concisely. The term "Summarizing" also describes the therapist's action in reviewing client experiences or responses during particular phases of therapy or within a life situation (Bruscia, 1987, p. 536). Summarizing is useful for closure or as a wrap-up of details. Summarizing as a technique can also help the therapist to remember both details and the salient points of the therapy.

Listening carefully throughout each session is vital to Summarizing. This technique requires the therapist to combine details of the client statements from Probing and Clarifying, along with the therapist's connections with and interpretations of those statements. One way to help you prepare for Summarizing is to think about it as a short session progress

note. The focus is on the therapeutic issue and therapeutic progress as resolved in both music and verbalization during the session. The Summary is designed to benefit the client by giving them a condensed synopsis that may support reflection on the therapy in between sessions.

The Summary might include the following: a statement on the focus or goals of the therapy; the therapeutic experiences engaged in or completed; details on the client's responses, both musically and verbally; concise statements from Connecting, Interpreting, or Confronting; reiteration of new client awareness or insight; therapeutic progress or growth; and a plan for the following session. One simple example is below.

- Therapist: "I am glad to have had time together today, Sherri. I know that you have been very concerned with how your anxiety is impacting your family and professional life. Today, you seemed very invested in the music we created to help you with relaxation. We also had a chance to talk about how your anxiety manifests in ways that make it difficult to be in social situations. You agreed that you are benefiting from the music and from your chance to express all of these difficult thoughts and emotions. I was pleased that you were able to work through your anger at some of the people from your past who you feel have contributed to your anxiety. It seems as if you have gained a new awareness of how things from your past still continue to bother you. It is great that you are committed to reflecting on this during the week and using our music to move to a more grounded, calm state. I look forward to hearing how this worked for you at our next session."

SUMMARY

Verbal Interventions describe the action in therapy when words and spoken language are used as the primary agent of change by both the therapist and client. The verbalization is designed to process, uncover, explore, and confront therapeutic issues

leading to client insight. Verbal Interventions include discussion of immediate experiences as well as conscious and unconscious material brought into the session by either the client or the therapist. Three clear requirements should be respected before any music therapist employs the techniques of Verbal Interventions: advanced education and training, client consent, and adherence to ethical practice. The select list of Verbal Interventions covered in this chapter contains ones that might be competently learned and employed by a student or young professional with the support of a basic education and training in mental health. They include the techniques of Connecting, Probing, Clarifying, Interpreting, Disclosing, Confronting, and Summarizing.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Verbal Interventions require the music therapist to have training and expertise in the complex ways in which humans exist in both the internal and external worlds. Take the time to read or reread the literature that supports your way of understanding the human experience. Focus particularly on the role that words play in those experiences.
- Examine your current music therapy practice and journal on how your foundational thinking about the human experience impacts your clinical music therapy work.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Each of the Verbal Interventions techniques discussed above gives a list of sample words or phrases to help you increase your basic verbal skills repertoire. For each of the techniques, write out for or five more samples of spoken language that you can use in your practice.

- Explore how Verbal Interventions techniques are used in both the scope and levels of music therapy practice. Journal on how Verbal Interventions are indicated or contraindicated at your level and scope of practice.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Verbal Interventions are more often used in particular types of practices, such as in mental health, where other professionals are also using Verbal Interventions. Imagine that the administration in this type of facility asks you to provide services that use Verbal Interventions. Write a short statement explaining why or why not you are the right person to do this type of work.

Chapter 12

UNDERSTANDING WORDS THROUGH MUSIC

Do you swear to tell the truth, the whole truth, and nothing but the truth? This well-worn phrase, used in legal courts and crime dramas, ignores the reality that truth is never simple. Words and spoken language are often mistakenly believed to be accurate and, therefore, truthful. However, words themselves tell only part of the picture. As discussed earlier in the book, the communicative meaning behind spoken language is highly dependent on qualities that are closely tied to music—pacing, inflection, timbre, articulation, and structure.

Think of a simple two-word phrase that you might hear during the course of a day, such as, "Come in." The musical qualities (pacing, inflection, timbre, articulation, and structure) with which these two words are spoken can significantly change the purpose and communicative intent. On the way to work, you might stop at a lovely new coffee shop that is eager for business. The proprietor graciously opens the door, and with slow pacing, a shaped inflection pattern, soft articulation of consonants, and plenty of room for response, sends a message of welcome as she entices you with, "Come in!" Contrast that with your first meeting of the day, when an overworked and angry boss practically shouts at you, "Come in!" Her sharp vocal timbre; quick, staccato rhythm; and monotone pitch send a very different message from that of the earlier coffee shop owner. Thank goodness your loving partner greets you later by using a gently rising and falling intonation as they slowly and calmly drawl out, "Come in." In each of these cases, it is the musical qualities, rather than the assigned meaning of the words, that truthfully communicate the intended message.

Music therapists have a unique sensitivity to how musical qualities of spoken language impart meaning. Attention to these musical qualities when speaking can enhance the therapeutic relationship and support therapy objectives no matter which of the four categories of verbalization you are using. Infusing extra-linguistic meaning through musical qualities can be used for a number of different therapeutic purposes.

- Creating, supporting, or sustaining the therapeutic relationship.
- Adding to or contrasting with the therapeutic environment.
- Emphasizing, highlighting, or underscoring the intent of the spoken language used.
- Connecting to or referencing the music used.

PACING

Verbal Pacing often sets the tone in the therapeutic space. Rhythm, tempo, duration, and meter are all intricately woven in the pacing of spoken language. A hurried barrage of words, no matter the linguistic content, might send a message to our clients of impatience or stress. On the other extreme, a languid pacing could be interpreted as indifference or even insecurity. The experience of meter, when the words are perceived to be grouped by 2s, 3s, or 4s, can feel foreign to a client if their primary language has a different feeling of meter from the one you are using. The emphasis on certain word sounds or syllables through duration are frequently connected to the manner in which people learn to speak within their particular community.

The implicit meaning communicated through verbal Pacing is highly dependent on the client's perception. Exposure to language in a client's culture and background generally creates a particular expectation of how the overall pacing of speech is heard and perceived. In some instances, a mismatch in pacing between you and your client might make it difficult for them to understand you and could limit the therapeutic bond. Pay special attention to this when your client's primary

language is different from your own. This might require you to assess your client's use of verbal Pacing in initial sessions. Your choice of verbal Pacing then can become a clinical strategy, similar in many ways to music strategies. Some suggestions for use are below:

- Use the same or similar verbal Pacing as your client to foster empathy, intimacy, and trust.
- Use modifications in verbal Pacing to foster an effective clinical environment. For example, a slow tempo and even meter in speech (as in music) could promote calm. Quicker speech might allow for greater attention to important Verbal Interactions or Interventions.
- Use verbal Pacing to connect to or reflect the rhythm, tempo, and meter of the music that will be introduced into the session.
- To further understand your own use of verbal Pacing, take a moment to reflect and consider these points.
  - Listen back to a recording of yourself using verbal skills in a clinical session. Note the qualities of Pacing you use—rhythm, tempo, duration, and meter. Do these qualities change during the session or in response to different events?
  - Assess each of your clients to determine their style or styles of verbal Pacing. Compare their use of verbal Pacing with yours.
  - Become familiar with the Pacing qualities used in a variety of languages. Pay particular attention to meter and whether the emphasis falls on a downbeat or upbeat. The duration of sounds in some languages can also change meaning.
  - In addition to culture and upbringing, your client's verbal Pacing might be an indicator of cognitive, developmental, linguistic, medical, or mental health challenges. Access literature on your particular practice to find out more.

INFLECTION

The term "inflection" might be better understood by music therapists as "intonation" or "melodic contour." Verbal Inflection is the rise and fall of the pitch qualities of words, phrases, and sentences. Speech therapists also use a similar term, "prosody," which combines Inflection and Pacing. The Inflection you use as you speak has the potential to significantly change the meaning of the words chosen. A sample might illustrate this. Take the phrase "Please come with me." If you use a downward melodic contour, the statement becomes a command. A rising inflection would change these four words into a question. A combination of rising and falling intonation would make it sound more like a possibility rather than probability.

Inflection in speech is also specific to particular languages and cultures. Some languages have a rising intonation, while others can be mostly falling. A disparity between your native inflection and your client's may cause miscommunication. As with Pacing, unusual or unexpected use of Inflection by a client could be an indication of cognitive, developmental, linguistic, medical, or mental health challenges. Again, assessing your client's use of inflection is critical in determining how your use of verbal Inflection can be a supportive clinical strategy. Some considerations:

- Play back a recording of your verbalizations within a clinical session, listening closely to how you use Inflection.
  - Do you have a distinctive style of verbal Inflection? In other words, do your phrases and sentences generally have a similar up or down contour?
  - Does the message conveyed by your Inflection match the content of the words you choose? Listen to yourself carefully to ensure that the linguistic content and the implied meaning created by Inflection match.

Although attention to verbal Inflection is important, too much focus on using Inflection as a strategy might result in your

speech not sounding authentic. Reflection and supervision can be very useful in helping you detect when your use of verbal Inflection sounds forced or insincere.

TIMBRE

The quality of our speaking voice, as well as of our singing one, is determined by a complex combination of physical, cognitive, cultural, emotional, and social influences. The term "timbre" describes how our voice sounds, both to ourselves and to other people. Much of the timbre of your voice is set long before beginning music therapy work. Some voices are thin and high. Some voices are low and resonant. A good source for reading about vocal timbre in music therapy is the 2018 book by Schwartz, Boyle, and Engen, *Functional Voice Skills for Music Therapists.*

When using verbal skills in practice, you will want to be alert to how your vocal timbre is aligned with the linguistic content of the words you choose and the clinical focus. With practice, most music therapists can learn to adjust the timbre of their speaking to make their words sound warm, confident, welcoming, professional, or any combination of intended emotional messaging. The combination of Timbre with linguistic content is particularly important in the verbalization categories of Verbal Framing and Verbal Exchanges. In these categories particularly, the abstract thoughts symbolized in language might be better conveyed for many clients through musical qualities, especially Timbre.

Consider the following in thinking about the impact of Timbre on your verbalizations.

- Check the pitch range in which you generally speak. Is it high? Low? Although pitch is a distinct musical element, the perception of pitch influences the perception of Timbre.
- Reflect or access supervision to help you determine whether the Timbre of your speaking voice contributes to your therapeutic presence and supports the effective use of verbal skills.

- Think about the explicit and implicit meaning of the words that you choose to use. Practice adjusting the Timbre of your voice to make your intended meaning. An example of this might be to use a warmer Timbre with verbal techniques of Empathy within Verbal Interactions.

ARTICULATION

The word "articulation" has multiple meanings, two of which are important in the development of verbal skills. First, "articulation," as it pertains to speech, describes how vowels and consonants are formed. Just as a music therapist must strive for clarity in playing or singing, verbal skills require the music therapist to provide clarity in speaking. This means forming vowels and consonants that can be heard and clearly understood by the client. This idea might seem overly simplistic, but its importance cannot be overlooked. Our words in any of the four verbal skills categories must be clearly articulated in order to be effective.

The reasons for poor speech articulation can be varied. Many music therapists have not had the opportunity for public speaking and thus might not have had the chance to practice distinct pronunciation. This is particularly critical in group work. A lack of confidence in using verbal skills might also lead to garbled articulation. There is also the possibility that issues of countertransference could unconsciously cause the therapist to speak indistinctly or in an inaudible manner. Once again, supervision or reflection can point out challenges you might have with speech articulation.

The second meaning of "articulation" will be more familiar to music therapists. Articulation is how we play a note or phrase. Some common articulation markings are staccato, legato, slur, or accent. All of these can be easily applied to the use of verbalization in music therapy. Musical Articulation in speech is often formed through precise pronunciation of vowels and consonants.

Another example here might help. Let's use the phrase "Come on." Using a sharp accent on the first word and staccato on the second would make this phrase sound quite harsh. Making both words sound legato and slurred might imitate the slightly irritated tone of a teenager.

Matching the intended meaning of your words, phrases, and sentences with musical Articulation can strengthen the explicit or implicit message. Think about the following when planning to use greater Articulation in your verbal work.

- What is the explicit message of the words used in any of the four verbal skills categories? How can changes in Articulation support that message?
- What is the implicit message of the words used in any of the four verbal skills categories? How can changes in Articulation support this message?
- Use reflection or supervision to help you monitor your use of Articulation, making sure that there is a congruence in what you say and how you say it.

STRUCTURE

Spoken language is plainly structured into words, phrases, sentences, and longer configurations such as paragraphs. However, music therapists can bring a wider understanding of Structure to our verbalization because we are uniquely sensitive to timing and phrasing within musical structures.

With your musician's ear, you can allow the spoken language used in music therapy to have a sense of flow in which both you and the client have a part to play. If you are unsure, think of the verbal skills discussed earlier as being part of a musical flow. Perhaps the introduction will be slow and then gently increase in tempo and inflection, leading to a space within the structure in which the client speaks. Your verbal response can complete the form, leading to a coda or ending in which both you and the client come to a mutual feeling of completion. This is only one example of how placing spoken

words within a context across time can add to the therapeutic emphasis. Some things to keep in mind:

- Verbal structures, as with musical structures, must include planned space for client response.
- Structuring Verbal Interactions and Verbal Interventions, particularly, should be planned with an ebb-and-flow of reciprocal communication. The structure does not need to be even—for instance, with the therapist's sentences and the client's sentences similar in length and duration—but should bring a balance that allows for give-and-take between therapist and client.
- Being mindful of Structure throughout an entire session can also allow for a balance between words and music as well as support session flow through beginning, middle, and end.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Read Dr. Aniruddh Patel's *Music, Language, and the Brain* for a more complete discussion of the connections between music and speech.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Review the verbal skills examples given in the chapters on Verbal Framing, Verbal Exchanges, Verbal Interactions, and Verbal Interventions. Practice infusing the musical qualities discussed in this chapter in each of the examples. Reflect on how these musical qualities support or enhance the communicative meaning of the words.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- You are using Verbal Framing and Verbal Exchanges techniques in your work with elderly clients in a dementia unit. Practice using each of the musical qualities discussed in this chapter to support or enhance the communicative meaning of the words.
- You are using Verbal Interactions and Verbal Interventions techniques for young adults with mental health challenges. Practice using each of the musical qualities discussed in this chapter to support or enhance the communicative meaning of the words.

Chapter 13

UNDERSTANDING MUSIC THROUGH WORDS

Throughout this journey into verbal skills in music therapy, we have sought to make connections and distinctions between these two very different modes of communication. At the end, though, the conversation cannot be black or white. In music therapy, there is, and must be, a gray area where music and words coexist. We cannot do our job without music, and we cannot do our job without words. In the current occupational climate, music therapists must have the skill to use words to clearly and compellingly describe and defend the work.

When writing about the "therapy" portion of music therapy, many music therapists assume language and vocabulary from other therapeutic fields such as medicine, mental health, rehabilitation, and special education. It has made sense to do this because it makes understanding easier for other professionals, regulatory and funding agencies, and clients, who already have this language template. An instance of this might be in a music therapist in the rehabilitation field who reports on a client's increased range of motion without ever mentioning that the agent of change for this client was actually the musical motivation to play the drum kit with a huge cymbal crash at the end of a meaningful phrase. It is possible that few of the people sitting at the table for this clinical report would understand the physical, sensory, cognitive, social, emotional, and musical ability that the client needed to access in order to play sforzando on the hi-hat.

Writing and speaking about music, then, calls for us to create an entirely new language—the language of music therapy. As explored in chapter 1, there are two key factors

necessary for language: an organizational system made up of discrete components and shared meaning within a social, cultural, or relationship context. As Aigen (2014) and others have argued, without a unique and specific language, the music therapy field cannot continue to develop and grow. The task ahead, for the individual therapist and for the field in general, is threefold:

- Adopt a common and shared vocabulary of music therapy.
- Agree on a useful and music focused syntax and grammar.
- Educate other professionals, regulatory and funding agencies, and clients to create an understandable and meaningful context.

To the single and often only music therapist, this call for change might seem like a huge challenge. However, there are a number of music therapy scholars and writers who have begun the process of suggesting music therapy language. This book provides an example of using existing vocabulary in a broader framework. It has taken the language proposed by Bruscia in his "Sixty-Four Clinical Techniques Used in Improvisational Music Therapy" (1987) and used it as a foundation for the development of basic verbal skills. Other music therapy language has been created by Dr. Michael Thaut and used in the Neurologic Music Therapy model adopted by those who have completed the NMT training. Another open source for music therapy–specific language can be found in the musical developmental levels proposed by Schwartz in her 2008 book, *Music, Therapy, and Early Childhood: A Developmental Approach.*

For the practitioner just beginning to develop basic verbal skills, it might be helpful to organize suggested verbalization to talk or write about music in music therapy according to aspects of the musicing experience discussed in chapter 10: specific musical details; details on the act of music-making; physical sensations connected to the music experience; the perceived social aspects of the music experience; the feelings that arise in

response to the music experience; or spiritual or transpersonal connections to the music-making. Below are lists of suggested words, phrases, and sentences that could be used when speaking or writing about your music therapy work. As before, the words and grammar use should be modified or adjusted to account for the client's cognitive, developmental, or linguistic capacity. Note that the intended communication partner is the client. The grammar and sentence structure could just as easily be adjusted to speak or write about the client and the client experience when reporting or evaluating.

Specific musical details:

- Your gradual increase in tempo showed consistent focus and regulation.
- That unexpected crescendo in the final phrase really created momentum for the group.
- It is great that you are able to initiate and sustain the entire melody and melodic contour.
- The dissonance you made with those minor seconds was quite remarkable.
- Your improvisation was really creative. You used an ABACA structure that gave lots of room for expanding on the primary melody.

Details on the act of music-making:

- Thanks for taking a risk by playing the melodic instruments rather than simple percussion.
- Your voice seemed to be softer and used more legato this time around.
- The marimba requires quite a bit of visual attention to strike the notes of the scale.
- That song has long spaces where the melody has a rest while the accompaniment plays.
- It was interesting that you played the melodic rhythm rather than the basic beat.

Physical sensations connected to the music experience:

- You seemed quite energized by the accelerando in that piece.
- It was great to see you inhale so deeply before singing that first phrase.
- Your accuracy when striking those repeated staccato notes showed such great physical effort.
- There are a number of harmonic progressions that seem to create a sense of calm and relaxation.
- I could tell that you were really listening to the melody and that you were able to show focus throughout.

Perceived social aspects of the music experience:

- Vocalizing that perfect fifth together seems to have allowed you to become more aware of your peers.
- Knowing when to come in on the downbeat all together without a cue shows how in tune you are with the music and with each other.
- Music is structured in time, so it helps us to have a mutual sense of expectations.
- When we sing with someone in harmony, it feels unified but individual at the same time.
- Look at how we all quickly entrained to the rhythm and started playing as one.

Feelings or emotions that arise in response to the music experience:

- A descending melody line often feels different emotionally than an ascending line.
- Because of the frequency vibrations, the tone bars we are using give a physical a sensation that some people have an emotional response to.
- Your rhythmic playing sounded quite disorganized and frantic. Is that an indication of how you are feeling now?
- It seemed as if you stopped your singing in the middle of the verse and then picked up again in the refrain. Was something going on for you at that moment?

- Musical scales are patterns that can help us predict what is coming. You showed some discomfort when we moved away from playing the scales.

Spiritual or transpersonal connections to the music-making:

- This song has been around for generations, and people seem to like how it reminds them of other aspects of their life.
- You closed your eyes and seemed truly transported as you sang those harmonies. Would you like to share what you were feeling or thinking?
- Could you feel the energy in the room when we began to play and move together?
- The timbre of your voice was so gentle and beautiful. Some people might describe it as soulful.
- Those close harmonies can give some people a chance for reflection.

Reflection: Explore, examine, read, or write about the meaning of words and language, including personal examination as well as synthesis of the literature.

- Read and reflect on the literature by Aigen, Bruscia, Thaut, and Schwartz mentioned in this chapter on creating a music therapy–specific language.
- Reread some of the foundational music therapy works that influenced your practice. Reflect on how they wrote about music within music therapy.

Repertoire: Curate samples of words, phrases, or sentences that can be used within each of the types of verbalization in each section.

- Record one of your music therapy sessions. Listen back and write down how you speak about the music within the session. Keep a list for future reference.

Rehearsal: Use vignettes to imagine or role-play different scenarios in which you would use verbal skills and practice them as a foundation in actual therapy.

- Imagine that you work in a school for children with developmental delays. Practice using each of the categories of talking or speaking about music in music therapy for both individual and group sessions.
- Imagine that you work in the rehabilitation unit of a hospital. Practice using each of the categories of talking or speaking about music in music therapy for both individual and group sessions.
- Imagine that you work in a nursing home in a unit for people with dementia. Practice using each of the categories of talking or speaking about music in music therapy for both individual and group sessions.
- Imagine that you work in hospice. Practice using each of the categories of talking or speaking about music in music therapy for both individual and group sessions.

Chapter 14

FINAL WORDS

The profession of music therapy is now well into the twenty-first century. The practice of music therapy has grown and evolved in ways the early founders might not have imagined. In your career as a music therapist, you might find yourself bending over a crib in a Neonatal Intensive Care Unit or sitting at the bedside of an elderly hospice patient. Your music therapy space might be in a prison cafeteria or a large community gathering. You might be rapping with teens or leading a client through imagery as you listen to music. Music therapy has undoubtedly broken through the boundaries of the clinic walls and found a valued place in physical and mental health, development, education, wellness, and community. This challenges the twenty-first century music therapist to bring broader expertise to the work, with a solid foundation in theory, best practices, and effective outcomes.

The music therapist of today must also be ready and willing to meet the needs of the twenty-first century client. In the current healthcare and educational environment, clients have extensive access to information and can seek out therapy that best serves their needs. The client recognizes that they can, and should, have agency over their own health and wellness. Clients and families who seek music therapy services bring their expectations to the table, and should have an equal voice in determining goals, outcomes, and treatment models. They understand the benefits of music therapy. It is then critical that the music therapist have a solid understanding of why, when, and how to implement specific strategies and interventions – including the use of words.

The basic verbal skills introduced in this book were designed to give the music therapist a clear and organized way

to understand how words in music therapy work. This clarity will hopefully assist you with planning for the most effective interventions. It can help you to communicate effectively with your clients and other professionals about treatment. It can provide a template for situating your practice in theory with respect to professional ethics and scope of practice. Most importantly, it can provide you with valuable tools for best serving your clients.

Throughout the book, the detailed examination of words and the distinctly defined categories of verbalization are all intended to support the view expressed from the very beginning – that in music therapy every single note, every single chord, every single rhythm, and yes, every single word we use with our clients should have intent, meaning, and purpose.

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